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Lawrence O. Gostin

Georgetown University Law Center, gostin@law.georgetown.edu

Lance Gable

Wayne State University Law School, lancegable@wayne.edu

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Lawrence O. Gostin

Professor of Law
Georgetown University Law Center
gostin@law.georgetown.edu

Lance Gable

Assistant Professor of Law
Wayne State University Law School
lancegable@wayne.edu

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THE HUMAN RIGHTS OF PERSONS WITH MENTAL DISABILITIES: A GLOBAL PERSPECTIVE ON THE APPLICATION OF HUMAN RIGHTS PRINCIPLES TO MENTAL HEALTH*

LAWRENCE O. GOSTIN**

LANCE GABLE***

It is not necessary to recount the numerous charters and declarations . . . to understand human rights . . . All persons are born free and equal in dignity and rights. Everyone . . . is entitled to all the rights and freedoms set forth in the international human rights instruments without discrimination, such as the rights to life, liberty, security of person, privacy, health, education, work, social security, and to marry and found a family. Yet, violations of human rights . . . are a reality to be found in every corner of the globe.¹

International human rights law provides a powerful, but often neglected, tool to advance the rights and freedoms of persons with mental disabilities. International law may seem marginal or unimportant in developed countries with democratic and constitutional systems of their own. Yet, even democracies often resist making reforms to mental health law and policy, and domestic courts do not always compel the changes necessary to improve the rights and welfare of persons with mental disabilities.² While many democracies have taken

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** Professor of Law, Georgetown University Law Center; Professor of Public Health, the Johns Hopkins Bloomberg School of Public Health; Director, Center for Law and the Public's Health (CDC Collaborating Center Promoting Health Through Law). Professor Gostin, while Legal Director of MIND (National Association for Mental Health) in the United Kingdom, brought several landmark mental health cases before the European Commission and Court of Human Rights.

*** Fellow, Center for Law and the Public's Health, Georgetown University Law Center.

1. Peter Piot & José Ayala-Lasso, *Foreword* to LAWRENCE O. GOSTIN & ZITA LAZZARINI, *HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC*, at vii (1997).

2. See, e.g., David L. Braddock & Susan L. Parish, *Social Policy Toward Intellectual Disabilities in the Nineteenth and Twentieth Centuries*, in *THE HUMAN RIGHTS OF PERSONS WITH INTELLECTUAL DISABILITIES: DIFFERENT BUT EQUAL* 83, 97-99 (Stanley S. Hett et al. eds., 2003) [hereinafter *DIFFERENT BUT EQUAL*] (explaining that legislation protecting the rights of

significant steps to enshrine in their national laws protections for the rights and freedoms of persons with mental disabilities, many of these same countries have failed to respect the human rights of persons with mental disabilities due to popular or political pressure.³ Additionally, international human rights law is obviously important for countries without democratic and constitutional systems because it may provide the only genuine safeguard against the abuse of persons with mental disabilities—abuse that may be based on political, social, or cultural grounds.⁴

International human rights law is important in the context of mental health because of two fundamental ideas unique to global protection of rights and freedoms. First, human rights law is the only source of law that legitimizes international scrutiny of mental health policies and practices within a sovereign country.⁵ Second, international human rights law provides fundamental protections that cannot be taken away by the ordinary political process.⁶

Prior to World War II, the international system consisted almost exclusively of interactions between sovereign states.⁷ The international community operated on the assumption that human rights violations within a country's borders were internal matters, and rarely were these violations subjected to serious external scrutiny.⁸ As the world came to terms with the unspeakable atrocities of the war, it became evident that the existing system at both the national and international levels had completely failed to adequately protect the rights and freedoms of individuals.⁹ The international community and the nascent human rights movement resolved to change fundamentally the perspective of international law to ensure that such wanton disregard

people with disabilities was not enacted until the late Twentieth Century in the United States or Britain).

3. See *id.* at 98 (discussing the United Kingdom's Disability Discrimination Act, which disappointed disability advocates by not going far enough to protect the rights of people with disabilities).

4. See SIDNEY BLOCH & PETER REDDAWAY, *PSYCHIATRIC TERROR: HOW SOVIET PSYCHIATRY IS USED TO SUPPRESS DISSENT* 280-330 (1977) (detailing international opposition and actions taken against the Soviet Union's misuse of psychiatry to advance political purposes).

5. See LOUIS HENKIN, *HOW NATIONS BEHAVE: LAW AND FOREIGN POLICY* 234 (2d ed. 1979) (explaining that the United States has been reluctant to enter into international agreements because it does not want to subject itself to scrutiny from other countries).

6. See LOUIS HENKIN, *THE AGE OF RIGHTS* 20-21 (1990) (discussing the fundamental nature of many human rights laws, which has made the laws binding either through custom or through international agreements).

7. GOSTIN & LAZZARINI, *supra* note 1, at 2.

8. *Id.*

9. *Id.*; see also HENKIN, *supra* note 5, at 319-20 (explaining that nations agreed to enact laws to prevent war).

of peace and human dignity would not recur.¹⁰ The human rights movement solidified the inherent rights and freedoms of individuals by recognizing these rights under international law and piercing the veil of national sovereignty to hold states accountable for violations.¹¹ Human rights, therefore, are not a matter simply between citizens and their government—even a democratically elected government.¹² Rather, human rights are a matter of international law enforceable against the state on behalf of persons living within or under the control of the state.¹³ This renders each country's mental health policies and practices subject to international human rights standards and susceptible to international monitoring and control.¹⁴

The second related idea is that human rights do not rely on government beneficence. Governments do not possess the power to grant or deny human rights and freedoms.¹⁵ Persons possess rights simply because of their humanity.¹⁶ Thus, persons with mental disabilities need not prove that they deserve certain rights or that they can be trusted to exercise them in socially and culturally acceptable ways. The fundamental nature of human rights can, therefore, serve as a basis to challenge unjust treatment of people with mental disabilities, even in the face of popular or political objections.

Human rights, then, afford all persons fundamental rights and freedoms and place duties on government to respect them. Rather than focusing on personal obligations, classic understandings of human rights center around a government's duty to respect rights and freedoms.¹⁷ Human rights law, strictly speaking, does not protect one individual against the harmful actions of another individual.¹⁸ However, a government can conceive its human rights duties broadly to include: (1) *respect*—the state's obligation not to infringe upon human rights, e.g., no arbitrary confinement; (2) *protection*—the state's obligation to prevent private violations, e.g., anti-discrimination laws; and (3) *fulfillment*—the state's obligation to promote human rights, e.g.,

10. GOSTIN & LAZZARINI, *supra* note 1, at 2.

11. *Id.*

12. *See id.* at 40 (discussing the need for governments to adhere to minimum standards on the treatment of individuals within their specific jurisdictions).

13. *Id.* at 8-9.

14. *See* HENKIN, *supra* note 6, at 21 (explaining that a member of an international agreement may report the violations of another member).

15. GOSTIN & LAZZARINI, *supra* note 1, at xiv.

16. *Id.*

17. *Id.* at 43.

18. *See, e.g.,* Case C-91/92, Paola Faccini Dori v. Recreb, 1994 E.C.R. I-3325, para. 20 (noting that a directive cannot be used to impose obligations on one individual against another individual).

education and services.¹⁹ Thus, international human rights law places the onus on the state to safeguard the human rights of all people, including individuals with mental disabilities.

This Article examines the human rights of persons with mental disabilities and the application and development of these rights by the various international and regional systems that have been established to protect human rights. An international system of human rights with universal application has been developed under the auspices of the United Nations.²⁰ Regional human rights systems have applied additional human rights protections to their respective geographic regions.²¹ Both the international and regional systems have addressed the human rights of persons with mental disabilities through treaties, declarations, and thematic resolutions.²² Moreover, regional institutions have incrementally formulated a body of law that protects the human rights of persons with mental disabilities.²³ These international systems, documents, institutions, and legal rulings have collectively spurred the development of tangible and recognizable human rights standards at the international and regional levels; they have also brought to light, and in some cases put an end to, ongoing human rights violations targeting persons with mental disabilities.²⁴ Further, the legal precedent and public pressure created by this body of international law has encouraged domestic governments to apply human rights principles to their policies affecting mentally disabled individuals at the national and sub-national level.²⁵ This Article devotes particular attention to the well-developed jurisprudence within the European system for the protection of human rights. This regional human rights system has advanced a rich and nuanced body of law protecting the human rights of persons with mental disabilities.

19. See generally HENRY J. STEINER & PHILIP ALSTON, *INTERNATIONAL HUMAN RIGHTS IN CONTEXT: LAW, POLITICS, MORALS* 361-66 (2d ed. 2000) (describing the liberal political tradition of Western civilization and its emphasis on state obligations to individuals).

20. GOSTIN & LAZZARINI, *supra* note 1, at 2.

21. *Id.* at 10-12.

22. See generally Stanley S. Herr, *From Wrongs to Rights: International Human Rights and Legal Protection*, in *DIFFERENT BUT EQUAL*, *supra* note 2, at 115, 118-37 (detailing several international and regional human rights initiatives).

23. See GOSTIN & LAZZARINI, *supra* note 1, at 11 (contending that regional systems are often more accessible and responsive to individual complaints than the broader international human rights system).

24. See *id.* at 11-12 (discussing the purpose behind several regional human rights systems).

25. See, e.g., Braddock & Parrish, *supra* note 2, at 97-98 (describing laws enacted by the U.S. and Great Britain regarding persons with disabilities).

First, this Article briefly examines three important relationships between mental health and human rights: (1) how coercive mental health policies can infringe on human rights; (2) how invasions of human rights can harm mental health; and (3) how the positive promotion of mental health and human rights can have mutually reinforcing and synergistic results.

Second, this Article reviews sources of law within the United Nations system of human rights protection. The principal source of law within the United Nations system is the International Bill of Human Rights, which includes two treaty-based covenants that are binding on states that have ratified the agreements.²⁶ These covenants, and the General Comments interpreting them, as well as the Universal Declaration of Human Rights, serve as the foundation of international human rights law.²⁷ The Article also examines the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI Principles).²⁸ These principles, while not formally binding, serve as influential aids in the interpretation of treaty obligations.²⁹ The Article additionally discusses other nonbinding statements, resolutions, and principles formulated at the international level that have furthered the development of human rights as applied to persons with mental disabilities. Two ongoing international initiatives are also considered: a proposal for a specialized international treaty on disability rights³⁰ and the forthcoming Mental Health Legislation Manual that the World Health Organization is developing.³¹

26. See Herr, *supra* note 22, at 121-22 (noting that these two covenants are the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights).

27. See *id.* at 118-23 (discussing the impact of the Universal Declaration of Human Rights and international treaties on the establishment of international human rights law).

28. G.A. Res. 119, U.N. GAOR, 46th Sess., 3d Comm., 75th plen. mtg., *reprinted in* [1991] 45 U.N.Y.B. 620, U.N. Sales No. E.92.I.1 [hereinafter *MI Principles*].

29. Eric Rosenthal & Leonard S. Rubenstein, *International Human Rights Advocacy under the "Principles for the Protection of Persons with Mental Illness,"* 16 INT'L J.L. & PSYCHIATRY 257, 268 (1993).

30. For an excellent discussion of the rights of persons with mental disabilities under existing human rights instruments and the debate over a new binding treaty specifically addressing the rights of persons with mental and intellectual disabilities, see Eric Rosenthal & Clarence J. Sundram, *Recognizing Existing Rights and Crafting New Ones: Tools for Drafting Human Rights Instruments for People with Mental Disabilities*, in DIFFERENT BUT EQUAL, *supra* note 2, at 467.

31. The World Health Organization is currently in the process of developing a Mental Health Legislation Manual that national governments may use as a guide to modernize their mental health laws and incorporate human rights concepts into national mental health practice. The Manual is part of a larger effort by the WHO Department of Mental Health and Substance Dependence "to protect and promote the human rights of people

Third, this Article discusses regional human rights systems in Europe, Africa, and the Americas. These regional systems operate under human rights instruments distinct from the United Nations system, but often contain similar human rights norms to those found in United Nations sources.³² These institutions have achieved substantial progress in the development of human rights law relevant to persons with mental disabilities.³³

Fourth, this Article examines the application of civil and political rights to mental health by international and regional systems of human rights protection. The corpus of international human rights law has focused predominantly on civil and political rights that prevent governments from taking or permitting actions that will reduce human rights among persons with mental disabilities.³⁴ The analysis will focus in depth on the most highly developed regional system of human rights protection—the European Convention of Human Rights³⁵ (ECHR) within the Council of Europe—but will also explore the intersection of human rights and mental health under the African and Inter-American regional systems. This part of the Article demonstrates the vast potential of human rights law in three important areas of mental health policy: (1) the right to fundamental fairness in compulsory admission and subsequent detention in mental institutions, e.g., legal representation, a hearing, and use of independent experts; (2) the right to humane and dignified conditions of confinement, e.g., avoidance of neglectful or abusive conditions in mental hospitals and harmful or intrusive forms of medical treatment; and (3) protection of the rights of citizenship, e.g., privacy, marriage, franchise, and association.

Finally, the Article discusses the application of social, economic, and cultural rights to mental health, particularly with respect to affirmative entitlements to mental health services. While the basis for recognizing economic, social, and cultural mental health rights exists

with mental disorders.” See World Health Organization, *WHO Project on Mental Health and Human Rights*, at http://www.who.int/hhr/mental_health/en/ [hereinafter *WHO Project*] (last visited Nov. 7, 2003) (explaining the purpose, history, and future of the Manual).

32. See GOSTIN & LAZZARINI, *supra* note 1, at 10-12 (describing several regional systems).

33. See generally David Harris, *Regional Protection of Human Rights: The Inter-American Achievement*, in *THE INTER-AMERICAN SYSTEM OF HUMAN RIGHTS* (David J. Harris & Stephen Livingstone eds., 1998) [hereinafter *INTER-AMERICAN SYSTEM*] (describing the achievements made by the Inter-American human rights system).

34. See GOSTIN & LAZZARINI, *supra* note 1, at 10-12 (discussing the rights targeted by each regional human rights system).

35. Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocol No. 11, Nov. 1, 1998, available at <http://www.echr.coe.int/Convention/WebCovenENG.pdf> [hereinafter *ECHR*].

in international and regional instruments, institutions at the international, regional, and domestic levels have been reluctant to pursue, define, or enforce such positive rights.³⁶ The right to health, however, has undergone a significant evolution in recent years through the adoption of several notable instruments and reports at the international and regional levels, most importantly General Comment 14 to the International Covenant of Economic, Social and Cultural Rights.³⁷ Additionally, the United Nations has appointed a Special Rapporteur on the right to health, whose mandate includes the right to mental health.³⁸ Concurrently, an expanding body of scholarly writing has examined the scope and application of the right to health.³⁹ The idea of affirmative mental health rights can fundamentally advance the dignity and welfare of persons with mental disabilities.

International human rights law, of course, leaves domestic governments with a wide range of discretion in relation to each of these rights and freedoms.⁴⁰ Nevertheless, this body of international law opens each of these areas to serious external scrutiny and may provoke domestic governments to recognize and respect these rights and freedoms.

36. See generally BRIGIT C.A. TOEBES, *THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW* 3-26 (1999) (offering an extensive account of the development of the right to health). But see GOSTIN & LAZZARINI, *supra* note 1, at 6-7 (explaining the lack of precise standards and definitions for the right to health); TOEBES, *supra*, at 259-72 (delineating complications with defining the content of the right to health).

37. *The Right to the Highest Attainable Standard of Health*, CESCR General Comment 14, U.N. Committee on Economic, Social and Cultural Rights, 22d Sess., Agenda Item 3, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter General Comment 14].

38. The Special Rapporteur, Paul Hunt, has released his first report. See *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur*, U.N. ESCOR Comm. on Human Rights, 59th Sess., Provisional Agenda Item 10, U.N. Doc E/CN.4/2003/58 (2003).

39. See Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457, 1467-74 (2001) (discussing the right to health under international treaties and institutions); Aart Hendriks, *The Right to Health: Promotion and Protection of Women's Right to Sexual and Reproductive Health Under International Law: The Economic Covenant and the Women's Convention*, 44 AM. U. L. REV. 1123, 1128-31 (1995) (explaining the scope of a woman's right to sexual and reproductive health); Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1, 8-17 (1994) (exploring differing definitions for an international right to health); Mary Ann Torres, *The Human Right to Health, National Courts, and Access to HIV/AIDS Treatment: A Case Study from Venezuela*, 3 CHI. J. INT'L L. 105, 111-14 (2002) (setting forth the importance of the international right to health by evaluating a Venezuelan Supreme Court case).

40. See Kinney, *supra* note 39, at 1464-67 (discussing the problems and promise of using customary international law to promote a human right to health).

I. THE FUNDAMENTAL RELATIONSHIPS BETWEEN MENTAL HEALTH AND HUMAN RIGHTS

Mental health and human rights, with notable exceptions, are rarely connected in thoughtful, systematic ways.⁴¹ Different philosophies, vocabularies, and social roles may explain the rarity of cross-disciplinary work.⁴² Yet, mental health and human rights are both powerful, modern approaches to advancing human well-being; by viewing these two fields together, rather than each in isolation, they become mutually reinforcing.⁴³ There are three relationships between mental health and human rights: (1) mental health policy affects human rights; (2) human rights violations affect mental health; and (3) positive promotion of both mental health and human rights are mutually reinforcing.⁴⁴

The first relationship is that mental health policies, programs, and practices can violate human rights.⁴⁵ Despite its rhetoric of “voluntarism” and noncoercion, mental health policy quintessentially involves the exercise of governmental power—the power to restrain, to treat, and to deprive individuals of basic rights of citizenship, e.g., voting, access to the courts, and controlling personal and financial affairs.⁴⁶ Mental health powers may be exercised beneficently for the welfare of the individual as well as family and society. However, governmental authority, by its very nature, affects a variety of personal interests such as autonomy, bodily integrity, privacy, property, and liberty.⁴⁷ These interests can, and do, give rise to human rights claims when mental health powers are exercised arbitrarily, in a discriminatory manner, or in the absence of a fair process.

41. Jonathan M. Mann et al., *Health and Human Rights*, in HEALTH AND HUMAN RIGHTS 7, 7 (Jonathan M. Mann et al. eds., 1999).

42. *Id.*

43. *Id.*

44. *Id.* at 11.

45. *Id.* at 11-14.

46. See Larry Gostin, *Human Rights in Mental Health: A Proposal for Five International Standards Based Upon the Japanese Experience*, 10 INT'L J.L. & PSYCHIATRY 353, 358-60 (1987) (discussing the importance of voluntary admission to mental hospitals and noting the prevalence of compulsory admission in Japan); see also Michael Allen & Vicki Fox Smith, *Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 342, 343-45 (2001) (describing how involuntary outpatient commitment violates various constitutional rights, including the right to privacy and the right to travel).

47. See Keith Graham, *Freedom, Liberalism and Subversion*, in LIBERTY AND LEGISLATION 205, 213-14 (Richard Hoggart ed., 1989) (asserting that the state has a decisive and pervading influence over every area of an individual's life).

The second relationship between the two approaches is that human rights violations adversely affect mental health.⁴⁸ The mental health effects of severe human rights violations, such as torture, rape, genocide, and inhuman and degrading treatment, are obvious and inherent.⁴⁹ Yet, the duration and extent of mental health problems remain under-appreciated.⁵⁰ Severe abuses of human rights result in serious, life-long mental suffering—not only by the individual, but often the family, community, and even future generations.⁵¹ Serious human rights violations usually are designed, not so much to inflict physical pain, but to break the human spirit—torture may be politically motivated to discourage resistance to government; rape and genocide may be employed to destroy ethnic and cultural identity.⁵² Even less drastic human rights violations, such as discrimination and invasion of privacy, can have adverse effects on mental well-being by undermining dignity and self-worth.⁵³

The third relationship between the two approaches is that mental health and human rights are inextricably linked.⁵⁴ Mental health and human rights are complementary approaches to the betterment of human beings. Some measure of mental health is indispensable for human rights because only those who possess some reasonable level of functioning can engage in political and social life.⁵⁵ Similarly, human

48. Mann et al., *supra* note 41, at 14-16.

49. Anne E. Goldfield et al., *The Physical and Psychological Sequelae of Torture: Symptomology and Diagnosis*, 259 JAMA 2725, 2727 (1988).

50. *Id.* at 2727-28.

51. *See id.* (describing the long-term effects that torture victims experience); *see also* KELLY DAWN ASKIN, WAR CRIMES AGAINST WOMEN: PROSECUTION IN INTERNATIONAL WAR CRIMES TRIBUNALS 264-67 (1997) (discussing how rape of women during times of war affects not only the victim, but also the community group to which she belongs).

52. *See* AHCENE BOULESBAA, THE U.N. CONVENTION ON TORTURE AND THE PROSPECTS FOR ENFORCEMENT 18-19, 36-37 (1999) (asserting that the infliction of mental suffering is a form of torture); *see also* ASKIN, *supra* note 51, at 264-67 (stating that the purpose of rape during war time is for one group to assert superiority and domination over another).

53. *See, e.g.*, Aart Hendriks, *Disabled Persons and Their Right to Equal Treatment: Allowing Differentiation While Ending Discrimination*, 1 HEALTH & HUM. RTS. 153, 153-55 (1995) (discussing how disability-based discrimination perpetuates human rights violations where those who hold power seek to reinforce their superiority); Aldred H. Neufeldt & Ruth Mathieson, *Empirical Dimensions of Discrimination Against Disabled People*, 1 HEALTH & HUM. RTS. 174, 178-81 (1995) (reviewing the disadvantages suffered by disabled people as a result of discrimination in education and employment opportunities).

54. Mann et al., *supra* note 41, at 16-18.

55. *See* NORMAN DANIELS, JUST HEALTH CARE 32-35 (1985) (stating that disease and disability can impair an individual's ability to function in society); *see also* Dan W. Brock & Norman Daniels, *Ethical Foundations of the Clinton Administration's Proposed Health Care System*, 271 JAMA 1189, 1189-90 (1994) (arguing that treatment for mental illness is an essential part of a comprehensive health plan, because mental health is necessary for individuals to pursue nearly all of their life goals).

rights are indispensable for mental health because they provide security from harm or restraint and the freedom to form and express beliefs that are essential to mental well-being.⁵⁶

Consider the importance of mental health and human rights to women in society. Without good mental health, women cannot function within the family, community, and workplace or participate in the political process.⁵⁷ Furthermore, women's mental health will suffer if they are subjected to discrimination, enforced conditions, violence in sexual relationships or marriage, limits on their possession or use of property, or restrictions on their social status or means of livelihood.⁵⁸ Seen in this way, a woman's mental health may improve by safeguarding her human rights—for example, by reforming laws relating to divorce, property distribution, labor, and rape.⁵⁹ A woman's power to secure her rights may improve if the government provides services and other conditions necessary for mental health.⁶⁰

II. SOURCES OF HUMAN RIGHTS LAW WITHIN THE UNITED NATIONS HUMAN RIGHTS PROTECTION SYSTEM

The body of law that has developed around international human rights is complex and evolving. The continuing development of human rights law and practice within the United Nations system has strengthened human rights protection for persons with mental disabilities.⁶¹ Nevertheless, a patchwork of sources created these protections and they have been enforced only sporadically in securing and promoting mental health.⁶² The International Bill of Human Rights, which contains the United Nations Charter, the Universal Declaration of Human Rights, and the two International Covenants of Human Rights, comprises the main source of law within the United Nations

56. See Rosenthal & Rubenstein, *supra* note 29, at 262-67 (discussing the rights outlined in the MI Principles and their emphasis on protecting the dignity and freedom of mentally ill persons and preventing discrimination against them).

57. See Pamela Goldberg, *Women, Health and Human Rights*, 9 PACE INT'L L. REV. 271, 275-77 (1997) (discussing the Beijing Declaration and Platform for Action and its focus on women's mental health in both societal and political contexts).

58. See *id.* at 279-80.

59. See *id.* at 283-85 (describing human rights problems and the need for legislation to enforce the human rights of women).

60. See *id.*

61. See Jamar, *supra* note 39, at 19-28 (setting forth and explaining several international documentary sources that provide substance for a right to health); see also Rosenthal & Rubenstein, *supra* note 29, at 257-77 (outlining the rights embodied in the United Nations MI Principles that serve as guidelines for protecting the rights of mentally ill people).

62. See Rosenthal & Rubenstein, *supra* note 29, at 284-85 (asserting that international scrutiny is needed to ensure that states enforce international agreements).

system.⁶³ While the International Bill of Human Rights forms the foundation for international human rights law, its provisions do not explicitly focus on the rights of persons with mental disabilities.⁶⁴ Consequently, the United Nations has adopted additional declarations, resolutions, and guidance documents specifically addressing the rights of persons with mental illness⁶⁵ and developmental disabilities.⁶⁶ Also, Special Rapporteurs appointed by the United Nations to investigate specific human rights areas have added guidance on the interface of human rights and mental disability.⁶⁷ The regional human rights systems in the Americas, Europe, and Africa further protect the human rights of persons with mental disabilities.⁶⁸ Part III of this Article discusses these systems in detail. The following part examines the application of human rights to persons with mental disabilities under the United Nations system, tracing the development of international human rights law through the prism of mental health. This part also discusses several international initiatives underway to clarify and advance these rights.

63. G.A. Res. 217 A, U.N. GAOR, 3d Sess., at 71, U.N. Doc. A/810 (1948) [hereinafter IBHR]. The International Bill of Human Rights also includes the Optional Protocol to the ICCPR. *Id.* The Optional Protocol empowers private persons to seek redress for Covenant violations from the Human Rights Committee, but is only available against states that have ratified it. See Dinah L. Shelton, *Individual Complaint Machinery under the United Nations 1503 Procedure and the Optional Protocol to the International Covenant on Civil and Political Rights*, in GUIDE TO INTERNATIONAL HUMAN RIGHTS PRACTICE 59, 67 (Hurst Hannum ed., 1984). The Optional Protocol binds a majority of the states that are parties to the Covenant. *Status of Ratifications of the Principal International Human Rights Treaties*, Office of the United Nations High Commissioner for Human Rights (July 7, 2003), available at <http://www.unhchr.ch/pdf/report.pdf>.

64. See IBHR, *supra* note 63 (describing rights applicable to every person).

65. *MI Principles*, G.A. Res. 119, *supra* note 28, [1991] 45 U.N.Y.B. at 620.

66. See *Declaration on the Rights of Mentally Retarded Persons*, G.A. Res. 2856, U.N. GAOR, 26th Sess., at 93, U.N. Doc. A/8429 (1971); see also *Declaration on the Rights of Disabled Persons*, G.A. Res. 3447, U.N. GAOR, 30th Sess., at 88, U.N. Doc. A/10034 (1975); *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*, G.A. Res. 96, 48th Sess., at 202, U.N. Doc. A/48/627 (1993) [hereinafter *Standard Rules*]. See generally Stanley S. Herr, *Rights of Disabled Persons: International Principles and American Experiences*, 12 COLUM. HUM. RTS. L. REV. 1 (1980) (exploring the application of human rights to persons with disabilities); DIFFERENT BUT EQUAL, *supra* note 2 (containing many articles about international human rights instruments).

67. See *supra* note 38 and *infra* notes 156-159 (discussing the reports of several Special Rapporteurs).

68. See, e.g., ECHR, *supra* note 35; American Convention on Human Rights, *opened for signature* Nov. 22, 1969, 9 I.L.M. 673 [hereinafter American Convention]; African Charter on Human and Peoples' Rights, June 27, 1981, 21 I.L.M. 58 [hereinafter African Charter].

A. *The United Nations Charter*

In its preamble, the United Nations Charter articulates the determination of the international community “to reaffirm faith in fundamental human rights, [and] in the dignity and worth of the human person.”⁶⁹ One of the central purposes of the United Nations is “[t]o achieve international co-operation in . . . promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction.”⁷⁰ Similarly, the United Nations “shall promote higher standards of living, full employment, and conditions of economic and social progress and development”⁷¹ and “universal respect for, and observance of, human rights and fundamental freedoms for all.”⁷² The Charter, adopted as a binding treaty in 1945, requires member states to advocate and to observe the human rights of all individuals, regardless of their racial, gender, ethnic, or religious differences.⁷³

B. *The Universal Declaration of Human Rights*

The Universal Declaration of Human Rights (UDHR) built upon the ideals of the United Nations Charter by identifying specific rights and freedoms that deserve promotion and protection.⁷⁴ With the adoption of the UDHR in 1948, the organized international community first attempted to establish “a common standard of achievement for all peoples and all nations” to promote human rights.⁷⁵ The Declaration’s thirty articles are based upon the principle that “[a]ll human beings are born free and equal in dignity and rights.”⁷⁶ The rights set forth in the UDHR are to be respected without discrimination, and include: the right to life, liberty, and security of person; the prohibition of slavery, torture, and cruel, inhuman, or degrading treatment; the right to an effective judicial remedy; the prohibition of arbitrary arrest, detention, and exile; freedom from arbitrary interfer-

69. U.N. CHARTER pmbl. (Oct. 24, 1945), *available at* <http://www.unhchr.ch/pdf/UNcharter.pdf> (last visited Nov. 7, 2003).

70. *Id.* art. 1, para. 3.

71. *Id.* art. 55(a).

72. *Id.* art. 55(c).

73. *Id.* arts. 55-56. Similarly, the Constitution of the World Health Organization states: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” CONSTITUTION OF THE WORLD HEALTH ORGANIZATION, *reprinted in* 14 U.N.T.S. 185, 186.

74. *See Universal Declaration of Human Rights*, pmbl. G.A. Res. 217 A, U.N. GAOR, 3d Sess., U.N. Doc. A/311 (1948) [hereinafter UDHR].

75. *Id.* pmbl.

76. *Id.* art. 1.

ence with privacy, family, or home; freedom of movement; freedom of conscience, religion, expression, and association; and the right to participate in government.⁷⁷ Notably, the UDHR does not separate or make distinctions among civil and political rights and economic, social, and cultural rights.⁷⁸

The UDHR characterizes economic, social, and cultural rights as “indispensable for [a person’s] dignity and the free development of his personality.”⁷⁹ Among the economic, social, and cultural rights included under the UDHR are several that are especially applicable to vulnerable populations, such as persons with mental disabilities: social security, work, equal pay for equal work, remuneration ensuring “an existence worthy of human dignity,” education, and the right to share in the cultural life of the community and “to share in scientific advancement and its benefits.”⁸⁰ Article 25 of the UDHR expressly recognizes an interest in health:⁸¹

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.⁸²

The UDHR has largely fulfilled the promise of its preamble, becoming the “common standard” for evaluating human rights conditions.⁸³ Although the United Nations did not promulgate the UDHR to legally bind member states, countries have so often applied and accepted its key provisions that the principles have attained the status of customary international law.⁸⁴ The UDHR embodies the international community’s understanding of “human rights” and has inspired

77. *Id.* arts. 3-28.

78. *See id.* arts. 1-28.

79. *Id.* art. 22.

80. *Id.* arts. 22-27.

81. During the drafting of the UDHR, the emphasis shifted from a direct focus on the right to health to its current focus on the economic necessities to achieve human health. *See TOEBES, supra* note 36, at 36-40 (tracing the progression of the text of the UDHR). During its second session, the Commission on Human Rights produced a draft declaration stating that “[e]veryone, without distinction as to economic and social conditions, has the right to the preservation of his health by means of adequate food, clothing, housing, and medical care.” *Id.* at 38.

82. UDHR, *supra* note 74, art. 25.

83. *Id.* pmbl.

84. *See* Hurst Hannum, *The Status of the Universal Declaration of Human Rights in National and International Law*, 25 GA. J. INT’L & COMP. L. 287, 317-52 (1995) (discussing the acceptance of the UDHR as customary international law).

successive generations of legally binding human rights instruments, including the international covenants on human rights and regional documents such as the European Convention of Human Rights.⁸⁵ The “common standard” established by the UDHR does not, however, specify the enumerated human rights beyond their most general context, and, as a result, has minimal direct application to the rights of persons with mental disabilities.⁸⁶

C. *Mental Health Rights Under International Human Rights Treaties*

1. *The International Covenants on Human Rights.*—The adoption of the UDHR set the stage for the International Covenants on Human Rights, a binding, treaty-based scheme to promote and protect human rights. The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) were adopted in 1966, and entered into force in 1976.⁸⁷ Similarly to the UDHR, the international covenants do not focus explicitly on the rights of persons with mental disabilities; rather, they adopt broad principles for safeguarding and promoting these rights.⁸⁸ Unlike the UDHR, the drafters of the international covenants separated the rights into two groups—civil and political rights and economic, social, and cultural rights—creating distinct instruments for each group of rights. The covenants address many of the same rights found in the UDHR and, in some instances, expand significantly upon the UDHR’s treatment of these rights.⁸⁹ The two

85. See *id.* at 290 (noting that nearly every international human rights agreement makes a reference to the UDHR).

86. See UDHR, *supra* note 74 (failing to articulate specific rights for individuals with mental disabilities).

87. International Covenant on Civil and Political Rights, Dec. 19, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) [hereinafter ICCPR]; International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976) [hereinafter ICESCR].

88. See ICCPR, *supra* note 87, art. 2, 999 U.N.T.S. at 173-74 (mandating remedies for violations of recognized rights and freedoms); see also ICESCR, *supra* note 87, art. 2, 993 U.N.T.S. at 5 (detailing rights under the agreement that states must enforce).

89. The ICCPR includes most, but not all, of the civil and political rights addressed in the UDHR. Compare ICCPR, *supra* note 87, arts. 1-27, 999 U.N.T.S. at 173-79 (covering rights of self-determination, freedom from discrimination, marriage and fair trial, among others, but not covering the right to own property alone), with UDHR, *supra* note 74, art. 17 (enumerating the right to own property alone). The ICESCR, by contrast, addresses economic, social, and cultural rights more extensively than the UDHR. See Marc-André Eissen, *The European Convention on Human Rights and the United Nations Covenant on Civil and Political Rights: Problems of Coexistence*, 22 BUFF. L. REV. 181, 182-83 (1973) (discussing the United Nations’ conception and enactment of the two covenants and the UDHR).

international covenants, however, diverge in their treatment of permissible limitations on the rights they enumerate.⁹⁰

The civil and political rights contained in the ICCPR protect individuals from government actions that infringe on their liberty, privacy, and freedom of expression and association.⁹¹ Persons with mental disabilities have frequently invoked these rights and benefited from the protection they provide. For example, the prohibition of cruel, inhuman, and degrading treatment has empowered mentally disabled persons subject to civil commitment to argue for more humane conditions of confinement and treatment.⁹² Likewise, the right not to be subject to arbitrary arrest or detention has bolstered efforts to require adequate procedural protections for persons with mental disabilities subject to civil or criminal confinement.⁹³

Sections of the ICESCR form the foundation for rights that impose affirmative duties on the state to provide services.⁹⁴ Such economic, social, and cultural rights include family protection, an adequate standard of living, education, and the right to share in scientific advancement and its benefits.⁹⁵ Article 12 of the ICESCR requires governments to recognize "*the right of everyone to the enjoyment of*

90. The ICCPR recognizes that certain rights are so fundamental as to be absolute and proscribes any derogation of them. ICCPR, *supra* note 87, art. 4.2, 999 U.N.T.S. at 174. Nonderogable rights include: the right to life; freedom from torture and from cruel, inhuman, or degrading treatment or punishment; the right to recognition as a person before the law; and freedom of thought, conscience, and religion. *Id.* arts. 6, 7, 16, 18, 999 U.N.T.S. at 174-75, 177-78. The ICCPR states that other rights may be justifiably limited under certain conditions, such as "[i]n time of public emergency which threatens the life of the nation" but only "to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with other obligations under international law and do not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin." *Id.* art. 4.1, 999 U.N.T.S. at 174. Freedom of movement may be justifiably limited where restrictions are "provided by law, are necessary to protect national security, public order . . . , public health or morals or the rights and freedoms of others." *Id.* art. 12.3, 999 U.N.T.S. at 176. The ICESCR, on the other hand, permits "such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society." ICESCR, *supra* note 87, art. 4., 993 U.N.T.S. at 5.

91. ICCPR, *supra* note 87, arts. 9.1, 18.1, 19.2, 22, 999 U.N.T.S. at 175, 178.

92. *See, e.g.,* Ashingdane v. United Kingdom, 93 Eur. Ct. H.R. (ser. A) at 19 (1985) (discussing the contention of a mentally disabled individual who claimed that his transfer to a higher security hospital resulted in a deprivation of his liberty).

93. *See, e.g.,* Winterwerp v. The Netherlands, 33 Eur. Ct. H.R. (ser. A) at 24-25 (1979) (finding that the judicial proceedings in the Netherlands' Mentally Ill Persons Act were inadequate procedural protections under section 4 of ECHR Article 5).

94. *See, e.g.,* ICESCR, *supra* note 87, art. 2, 993 U.N.T.S. at 5 (requiring signatory states to guarantee the rights articulated in the ICESCR).

95. *Id.* arts. 10-15, 993 U.N.T.S. at 7-9.

the highest attainable standard of physical and mental health."⁹⁶ Persons with mental disabilities and their advocates have utilized many of these economic, social, and cultural rights to advance access to treatment in the community, develop more effective and humane treatments for mental illness, and increase the availability of educational and vocational training programs that target persons with mental disabilities.⁹⁷

2. *Human Rights Treaties.*—Persons with mental disabilities who are also members of other vulnerable groups may receive additional human rights protections under four other existing international treaties. United Nations conventions on the rights of women,⁹⁸ children,⁹⁹ and racial minorities¹⁰⁰ have established a more rigorous exposition of human rights directly pertinent to these specific groups. The United Nations also has promulgated a convention prohibiting torture and inhuman or degrading treatment.¹⁰¹ This convention, while not explicitly addressing mental health, is notable because persons with mental disabilities may be subjected to cruel treatment in institutions, or even in the community.¹⁰² The rights found in the foregoing conventions are targeted more toward the concerns of the protected groups and they may, in some cases, offer more substantial protections than the more general principles found in the ICCPR and ICESCR. The Convention on the Rights of the Child, for example, provides that a "mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance, and facilitate the child's active participation in the community."¹⁰³ Moreover, each of these conventions creates distinct moni-

96. *Id.* art. 12, 993 U.N.T.S. at 8 (emphasis added).

97. See, e.g., Gerard Quinn et al., *Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments, in THE CONTEXT OF DISABILITY* 59-73 (2002) (detailing the manner in which nations should implement and enforce the rights outlined in the ICESCR).

98. Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDEW].

99. Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 43 [hereinafter CRC].

100. International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 211 [hereinafter ICERD].

101. Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Dec. 10, 1984, 1465 U.N.T.S. 113 [hereinafter Torture Convention]. This convention prohibits intentionally inflicting physical or mental pain for any reason, including discrimination based on mental disability. *Id.* art. 1, 1465 U.N.T.S. at 113-14.

102. See Neufeldt & Mathieson, *supra* note 53, at 178-83 (describing discrimination against disabled individuals in education and in the workforce).

103. CRC, *supra* note 99, art. 23, 1577 U.N.T.S. at 51.

toring bodies to oversee the enactment of and adherence to convention rights.¹⁰⁴ The monitoring bodies, in turn, have interpreted the conventions to support the human rights of persons with mental disabilities.¹⁰⁵ These monitoring bodies may provide persons with mental disabilities within the covered groups additional opportunities for oversight.¹⁰⁶

The rights contained in the International Covenants and the four specific conventions mentioned above have binding effect on all states that have signed and ratified them.¹⁰⁷ These instruments, therefore, establish a base level of human rights protection and the expectation that signatory states will respect these rights. The widespread international acceptance of the ICCPR and ICESCR suggests that the rights they contain may have attained the status of customary international law, which, at least in time, would make them applicable even to non-signatory states.¹⁰⁸ The other conventions, while less likely to be binding through customary international law, have nevertheless been widely ratified and have, thus, added to a meaningful international human rights framework.¹⁰⁹

D. Clarifying Human Rights Under the United Nations System: General Comments, Declarations, Resolutions, Reports, and Principles

The binding treaties discussed above establish the underpinnings of the United Nations system of human rights. The norms and principles they contain, however, do not specifically address the rights of persons with mental disabilities.¹¹⁰ Traditionally, monitoring bodies

104. See, e.g., *id.* art. 43, 1577 U.N.T.S. at 58-59 (establishing the Committee on the Rights of the Child to oversee enactment of the convention).

105. See Theresia Degener, *Disability as a Subject of International Human Rights Law and Comparative Discrimination Law*, in *DIFFERENT BUT EQUAL*, *supra* note 2, at 157 (noting that monitoring bodies have adopted interpretive documents to support the rights of people with mental disabilities).

106. See *id.* at 157-59 (discussing the interpretations of several treaty-monitoring bodies that have safeguarded the rights of individuals with disabilities).

107. E.g., CRC, *supra* note 99, art. 50.3, 1577 U.N.T.S. at 61 (declaring that the Convention's provisions and amendments are binding on signatory states).

108. See RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW OF THE UNITED STATES § 102 (1986) (declaring that "customary international law results from a general and consistent practice of states followed by them from a sense of legal obligation").

109. The conventions, as widely accepted international law, exert pressure on nations to comply with their standards. See HENKIN, *supra* note 5, at 44-45 (describing the impact of international norms on government behavior).

110. The ICCPR, for example, does not specifically address these rights. ICCPR, *supra* note 87, 999 U.N.T.S. at 172-79.

operating under the treaties have not adequately enforced them.¹¹¹ Consequently, further guidance, development, and explanation have been necessary to ensure that member states can effectively apply the rights contained in these instruments to protect and promote mental health.

Beginning in the 1970s, the United Nations developed a number of comments, declarations, resolutions, and guidance documents that have elaborated on the application of general rights to persons with mental disabilities.¹¹² This evolution has occurred gradually, incrementally, and often inconsistently.¹¹³ General Comments to the International Covenants, General Assembly resolutions, Special Rapporteur reports on health and disability rights, and other related initiatives, some of which are ongoing as of this writing, have clarified the rights of persons with mental disabilities.¹¹⁴ Most significantly, the United Nations has approved principles that directly apply to the rights of persons with mental disabilities.¹¹⁵

1. *Principles for the Protection of Persons with Mental Illness.*—The United Nations designated the years 1983 to 1992 as the “Decade for Disabled Persons.”¹¹⁶ The Human Rights Commission appointed two special rapporteurs, Erica-Irene Daes¹¹⁷ and Leandro Despouy,¹¹⁸ to report on human rights abuses and to advance the welfare and rights of persons with disabilities, including the mentally ill.¹¹⁹ Following an

111. See Degener, *supra* note 105, at 159 (describing the international human rights regime as a “toothless tiger”).

112. See *id.* at 155-57 (discussing the United Nations’ movement in the 1970s to recognize individuals with disabilities as subjects of human rights).

113. See, e.g., *id.* at 156 (noting that the U.N. Commission of Human Rights failed to capitalize on an opportunity to create a binding international human rights instrument to protect persons with disabilities in institutions).

114. See, e.g., *Persons with Disabilities*, CESCR General Comment 5, U.N. Committee on Economic, Social and Cultural Rights, 11th Sess., U.N. Doc. E/1995/22 (1994); General Comment 14, *supra* note 37.

115. *MI Principles*, G.A. Res. 119, *supra* note 28, [1991] 45 U.N.Y.B. at 620.

116. Implementation of the World Programme of Action Concerning Disabled Persons, [1982] 36 U.N.Y.B. 983, U.N. Doc. A/37/632.

117. Erica-Irene A. Daes, *Principles, Guidelines and Guarantees for the Protection of Persons Detained on Grounds of Mental Ill-Health or Suffering from Mental Disorder*, U.N. ESCOR, U.N. Doc E/CN.4/Sub.2/17 (1986).

118. UNITED NATIONS, ECONOMIC AND SOCIAL COUNCIL, COMMISSION ON HUMAN RIGHTS, SUB-COMMISSION ON PREVENTION OF DISCRIMINATION AND PROTECTION OF MINORITIES, HUMAN RIGHTS AND DISABILITY, U.N. Doc. E/CN.4/Sub.2/31 (1991).

119. See Rosenthal & Rubenstein, *supra* note 29, at 258 (discussing the findings of the special rapporteurs).

extensive drafting process beginning in the late 1970s,¹²⁰ and considerable debate among mental health professionals and civil libertarians, the United Nations General Assembly adopted the MI Principles, a detailed international statement of the rights of persons with mental illness.¹²¹ The MI Principles are a useful interpretive guide to United Nations and regional human rights conventions.

The MI Principles begin by enunciating fundamental freedoms and rights to such things as the “best available” mental health care; respect for inherent dignity; protection from exploitation, physical or other abuse, and degrading treatment; nondiscrimination; natural justice prior to a finding of incapacity; and, more generally, the right to exercise all rights found in the International Bill of Human Rights and other relevant instruments.¹²² The MI Principles recognize the inherent difficulties of protecting human rights in institutions by noting that care should, when possible, be administered in the community.¹²³ The duty to treat patients in the least restrictive environment and to maintain and improve their autonomy reinforces this preference for community care.¹²⁴

The MI Principles adopt a set of legal standards and procedures for involuntary admission to a hospital.¹²⁵ A mental health institution may involuntarily admit a person only if: (1) she has a mental illness diagnosed under internationally accepted medical standards; and (2) there is a serious possibility that immediate harm will happen to her or to others; or (3) if she is severely mentally ill, has impaired judgment, and there will be a drastic deterioration of her illness if the facility does not admit her.¹²⁶ To ensure that an involuntary admission meets the preceding requirements, a patient will receive a fair hearing by a judicial or other independent and impartial review body.¹²⁷ During this hearing, the patient has the right to representa-

120. *Human Rights and Scientific and Technological Developments*, G.A. Res. 53, U.N. GAOR, 33d Sess., at 144, U.N. Doc. E/1978/33 (1978). The earliest draft was prepared by a committee under the auspices of the International Association of Penal Law and the International Commission of Jurists. *THE PROTECTION OF PERSONS SUFFERING FROM MENTAL DISORDER: PROCEEDINGS OF TWO MEETINGS OF EXPERTS HELD AT THE INTERNATIONAL INSTITUTE OF HIGHER STUDIES IN CRIMINAL STUDIES IN SIRACUSA MAY 29-31, 1980 AND DECEMBER 1-4, 1980* (1980).

121. *MI Principles*, G.A. Res. 119, *supra* note 28; see also Rosenthal & Rubenstein, *supra* note 29, at 260-99 (providing a comprehensive analysis of the MI Principles).

122. *MI Principles*, G.A. Res. 119, *supra* note 28, principle 1, [1991] 45 U.N.Y.B. at 621.

123. *Id.* principles 3, 7, [1991] 45 U.N.Y.B. at 621-22.

124. See *id.* principle 9, [1991] 45 U.N.Y.B. at 622 (prescribing the right to treatment in the least restrictive environment).

125. *Id.* principle 16, [1991] 45 U.N.Y.B. at 624.

126. *Id.*

127. *Id.* principles 17, 18, [1991] 45 U.N.Y.B. at 624-25.

tion, can call independent experts, and can review all evidence given and the reasons for the review body's decision.¹²⁸ The MI Principles offer less robust protection against mandatory treatment. Principle 11, addressing consent to treatment, offers a complex and detailed political compromise between autonomy and paternalism.¹²⁹

Persons with mental illness are entitled to a number of civil and political rights including privacy and confidentiality, freedom of communication, access to information, and freedom from forced labor.¹³⁰ The MI Principles also enunciate a set of economic, social, and cultural rights including the right to health and social services appropriate to health needs, an individualized treatment plan, recreational and educational services, and resources for mental health facilities comparable to other health facilities.¹³¹

The MI Principles comprise the most direct expression of human rights in the context of mental illness issued to date by the United Nations.¹³² The MI Principles, however, are not a panacea for mental disability rights in all contexts. The civil and political rights found in the MI Principles apply to all persons with mental disability, regardless of whether they reside in a mental health facility.¹³³ The economic, social, and cultural rights, by contrast, only apply to patients in mental health facilities.¹³⁴ Notably, the MI Principles apply to all persons ad-

128. *Id.*

129. *Id.* principle 11, [1991] 45 U.N.Y.B. at 622-23; see Caroline Gendreau, *The Rights of Psychiatric Patients in the Light of the Principles Announced by the United Nations: A Recognition of the Right to Consent to Treatment?*, 20 INT'L J.L. & PSYCHIATRY 259, 267-76 (1997) (explaining Principle 11 in detail). Some commentators have criticized this compromise, stating that the MI Principles do not give patients sufficient autonomy. See Rosenthal & Rubenstein, *supra* note 29, at 264 (discussing the tension between informed consent and physician authority); Rosenthal & Sundram, *supra* note 30, at 483 (asserting that the MI Principles raise an expectation that cannot be met by mental health facilities). The United States Supreme Court has addressed the issue of whether mentally ill defendants can be forced to undergo treatment without their consent to render them competent to stand trial. See *Sell v. United States*, 123 S. Ct. 2174 (2003). The Supreme Court established that it was constitutional to administer antipsychotic drugs to a mentally ill defendant so that he would be competent to stand trial. *Id.* at 2178. The Court held that this practice is acceptable only if the treatment is medically appropriate, it is unlikely that any drug side effects will undermine the fairness of the trial, and the treatment is necessary to further important governmental interests in relation to the trial. *Id.* at 2184-85.

130. *MI Principles*, G.A. Res. 119, *supra* note 28, principles 6, 13, 19, [1991] 45 U.N.Y.B. at 622-23, 625.

131. *Id.* principles 8-10, 13, 14, [1991] 45 U.N.Y.B. at 622-24.

132. Rosenthal & Rubenstein, *supra* note 29, at 259.

133. See *MI Principles*, G.A. Res. 119, *supra* note 28, principle 1(5), [1991] 45 U.N.Y.B. at 621 ("Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights.").

134. *Id.* principles 7, 13, [1991] 45 U.N.Y.B. at 622-23.

mitted to a mental health facility, regardless of whether they are in fact mentally ill.¹³⁵

2. *General Disability Provisions Applied to Persons with Mental Disabilities.*—In addition to the MI Principles, the United Nations has promulgated several other nonbinding disability-specific instruments, including declarations outlining the rights of mentally-retarded¹³⁶ and disabled persons,¹³⁷ and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (the Standard Rules).¹³⁸ These instruments, while not specifically targeted at mental disabilities, generally apply human rights to persons with any type of disability. The Declaration on the Rights of Disabled Persons (the Disability Declaration), adopted in 1975, broadly defines a person with disabilities as “any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of a deficiency, either congenital or not, in his or her physical or mental capabilities.”¹³⁹ The Disability Declaration asserts an extensive set of civil, political, economic, social, and cultural rights, including rights to “medical, psychological and functional treatment”¹⁴⁰ and economic and social security.¹⁴¹ Importantly, the Disability Declaration also endorses community integration efforts for persons with disabilities.¹⁴² These rights clearly apply to persons with both physical and mental disabilities.¹⁴³

The Decade for Disabled Persons culminated with the World Conference on Human Rights in 1993. The Vienna Declaration from

135. *Id.* principle 24, [1991] 45 U.N.Y.B. at 625; see Eric Rosenthal & Clarence J. Sundram, *International Human Rights in Mental Health Legislation*, 21 N.Y.L. SCH. J. INT'L & COMP. L. 469, 489 (2002) (noting the importance of this provision since the lack of other resources and facilities means that many countries utilize mental health institutions to house persons that are not mentally ill).

136. Declaration on the Rights of Mentally Retarded Persons, G.A. Res. 2856, *supra* note 66, at 449; see Rosenthal & Sundram, *supra* note 135, at 487-88 (explaining the significance of the rights outlined in the Declaration).

137. Declaration on the Rights of Disabled Persons, G.A. Res. 3447, *supra* note 66, at 528.

138. *Standard Rules*, G.A. Res. 96, *supra* note 66, [1993] 47 U.N.Y.B. at 977; see also *Tallinn Guidelines for Action on Human Resources Development in the Field of Disability*, G.A. Res. 70, 44th Sess., Annex, Agenda Item 101, [1989] 43 U.N.Y.B. 584, U.N. Doc. A/441/775 (1989).

139. Declaration on the Rights of Disabled Persons, G.A. Res. 3447, *supra* note 66, art. 1.

140. *Id.* art. 6.

141. *Id.* art. 7.

142. *Id.* art. 9; see also *id.* art. 5 (providing that persons with disabilities are entitled to live in environments that allow them to be “as self-reliant as possible”).

143. See *supra* note 139 and accompanying text (noting the broad definition of “disabled person” provided by article 1 of the Disability Declaration).

that conference recognized that persons with disabilities were “unreservedly” due all human rights and fundamental freedoms.¹⁴⁴ The Vienna Declaration also presented a call to action to increase awareness of human rights in the context of disability.¹⁴⁵ The Standard Rules were an outgrowth of that call to action adopted by the General Assembly.¹⁴⁶

The Standard Rules adopt a broader approach to disability rights than the MI Principles, focusing on the equalization of opportunities and participation in all aspects of society.¹⁴⁷ The Rules recognize that “[p]ersons with disabilities are members of society and have the right to remain within their local communities.”¹⁴⁸ In order to achieve equalization of opportunities, the Standard Rules present a series of affirmative rights for the state to implement while guaranteeing that persons with disabilities have a meaningful voice in the development of policies.¹⁴⁹ The Rules encourage states to provide effective medical care, including preventive care, given by adequately trained personnel.¹⁵⁰ Rehabilitation services should be available in the local community.¹⁵¹ The Standard Rules grant persons with disabilities affirmative rights to accessible public facilities, integrated educational and vocational settings, favorable employment conditions and hiring practices, and social security and income maintenance.¹⁵² The Standard Rules further assert that the state should afford persons with disabilities equal opportunities to fully participate in society through measures that promote full participation in family life, as well as cultural, recreational, and religious activities.¹⁵³ States should also endeavor to raise awareness about disability issues to reduce the stigma and misunder-

144. Vienna Declaration and Programme of Action, World Conference on Human Rights, Vienna, June 25, 1993, para. 63, U.N. Doc. A/CONF.157/23 [hereinafter Vienna Declaration]. The Vienna Declaration solidified the notion that persons with physical and mental disabilities were subject to the protections from discrimination found in Article 26 of the ICCPR. See ICCPR, *supra* note 87, Art. 26, 999 U.N.T.S. at 179. Article 26 prohibits discrimination and guarantees “to all persons equal and effective protection against discrimination on any ground such as race, colour, sex . . . or other status.” *Id.* The Vienna Declaration specifically included a physical or mental disability within the scope of “other status.” See Vienna Declaration, *supra*, para. 63 (calling upon nations to adopt legislation to prohibit discrimination against disabled persons).

145. See Vienna Declaration, *supra* note 144, paras. 63-65.

146. See *Standard Rules*, G.A. Res. 96, *supra* note 66, [1993] 47 U.N.Y.B. at 977.

147. *Id.* at Introduction, arts. 13-15, 24-27, [1993] 47 U.N.Y.B. at 978-80.

148. *Id.* at Introduction, art. 26, [1993] 47 U.N.Y.B. at 980.

149. *Id.* at Rules 2-12, [1993] 47 U.N.Y.B. at 982-85.

150. *Id.* at Rule 2, [1993] 47 U.N.Y.B. at 982.

151. *Id.* at Rule 3, [1993] 47 U.N.Y.B. at 982.

152. *Id.* at Rules 5-8, [1993] 47 U.N.Y.B. at 982-84.

153. *Id.* at Rules 9, 10, 11, 12, [1993] 47 U.N.Y.B. at 981-85.

standing associated with disability and to ensure adequate training of personnel.¹⁵⁴

The United Nations encouraged legal and economic reforms to achieve these goals.¹⁵⁵ The Standard Rules, unlike the MI Principles, provide for a Special Rapporteur and enforcement committee to oversee their implementation.¹⁵⁶ These oversight mechanisms have allowed for further development of the provisions of the Standard Rules and the collection of information regarding national efforts to comply.

The developments of disability rights under the Standard Rules and through the activities of the Special Rapporteur are highly relevant to the rights of persons with mental disabilities. Bengt Lindqvist, the Special Rapporteur on disability from 1994-2002, has stated that the Standard Rules do not systematically address the needs and rights of persons with developmental and psychiatric disabilities.¹⁵⁷ Yet, the Standard Rules give guidance on active participation in society not addressed in the MI Principles.¹⁵⁸ Lindqvist has commented that the Standard Rules and MI Principles are complementary and that both should apply to persons with mental disabilities.¹⁵⁹

Governments may argue that they are not obliged to conform with international resolutions, rendering them virtually meaningless as a force for influencing mental health policies.¹⁶⁰ A strong argu-

154. *Id.* at Rules 1, 19, [1993] 47 U.N.Y.B. at 981, 987.

155. *Id.* at Rules 15, 16, [1993] 47 U.N.Y.B. at 986.

156. The Special Rapporteur for Disability from 1994-2000, Bengt Lindqvist, authored several reports on the implementation and interpretation of the Standard Rules. *See infra* note 157. Lindqvist's term expired in December 2002. *See* United Nations Enable, *Sheikha Hessa Appointed New Special Rapporteur for Disability* (June 5, 2003), at <http://www.un.org/esa/socdev/enable/rapporteur2003.htm>. United Nations Secretary General Kofi Annan appointed Sheikha Hessa as Special Rapporteur for Disability for 2003-2005. *Id.*

157. Bengt Lindqvist, *Final Report of the Special Rapporteur of the Commission for Social Development on Monitoring the Implementation of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities on His Second Mission, 1997-2000*, U.N. Doc. E/CN.5/2000/3, paras. 107-111, 118, 149, available at <http://www.un.org/esa/socdev/enable/disecn003e0.htm> [hereinafter *Second Mission*]; Bengt Lindqvist, *Report of the Special Rapporteur of the Commission for Social Development on Monitoring the Implementation of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities on His Third Mandate, 2000-2002*, U.N. Doc. E/CN.5/2002/4, paras. 38-75, available at <http://www.un.org/esa/socdev/enable/disecn520024e0.htm> [hereinafter *Third Mandate*].

158. *See* Rosenthal & Sundram, *supra* note 135, at 475-77 (noting the inherent shortcomings of the MI Principles and the revolutionary nature of the Standard Rules).

159. *Second Mission*, *supra* note 157, paras. 113, 152.

160. *See* Rosenthal & Rubenstein, *supra* note 29, at 268 ("U.N. General Assembly resolutions, unlike treaties and customary international law, are not directly binding on states.") (citations omitted); Rosenthal & Sundram, *supra* note 135, at 479-80 (discussing the characteristics of binding and nonbinding international law).

ment, however, can be made that international principles such as the MI Principles and Standard Rules do have significant practical importance.

First, they help establish international human rights norms by creating a baseline of fair and decent treatment of persons with mental disabilities.¹⁶¹ The MI Principles in particular have been described as creating “minimum United Nations standards for the protection of fundamental freedoms and human and legal rights of persons with mental illness.”¹⁶² The Principles formalize the rule that international standards trump inconsistent local practices that do not meet human rights standards.¹⁶³ The guidance provided by international principles similarly provides states with a standard to evaluate their own level of compliance with international human rights norms on mental disability.¹⁶⁴

Second, the international principles enable fairer and more effective monitoring of psychiatric abuses because international and non-profit organizations have a standard by which they judge extant mental health policies.¹⁶⁵ The legitimization of international standards will compel states to participate and cooperate with international investigations on mental disability rights.¹⁶⁶ International monitoring organizations can, in turn, use these principles to more clearly and credibly identify rights violations and oblige states to take steps to remedy them.¹⁶⁷

Finally, and most importantly, countries can use resolutions as interpretive guides to international treaty obligations. International

161. See Rosenthal & Sundram, *supra* note 135, at 492 (stating that U.N. human rights standards should not be viewed as model laws, but rather as minimum standards that protect basic rights).

162. UNITED NATIONS, ECONOMIC AND SOCIAL COUNCIL, COMMISSION ON HUMAN RIGHTS, HUMAN RIGHTS AND SCIENTIFIC AND TECHNOLOGICAL DEVELOPMENTS, REPORT OF THE WORKING GROUP ON THE PRINCIPLES FOR THE PROTECTION OF PERSONS WITH MENTAL ILLNESS AND FOR THE IMPROVEMENT OF MENTAL HEALTH CARE, U.N. Doc. E/CN.4/1991/39 (1991). This view was shared by the Despouy report to the U.N. Human Rights Commission. UNITED NATIONS, ECONOMIC AND SOCIAL COUNCIL, COMMISSION ON HUMAN RIGHTS, HUMAN RIGHTS AND DISABILITY, U.N. Sales No. E.92.XIV.4 (prepared by Leandro Despouy), *available at* <http://www.un.org/esa/socdev/enable/dispaperdes0.htm> (last visited Sept. 28, 2003).

163. See Rosenthal & Rubenstein, *supra* note 29, at 269-70 (noting that the MI Principles set international law standards and local custom does not excuse states' compliance with these standards).

164. *Id.* at 270.

165. *Id.* at 269.

166. See *id.* (stating that international standards ensure that monitoring bodies will subject states to a single standard).

167. See *id.* (noting that the internationalization of detailed standards helps states identify and prosecute fundamental human rights violations).

human rights principles, such as the MI Principles, may be invoked by domestic courts or incorporated into domestic legislation.¹⁶⁸ Regional human rights systems have utilized international resolutions or principles to construe the scope of human rights protection under regional instruments.¹⁶⁹ Over time, the increased acknowledgment of and adherence to these international standards advance them toward recognition as customary international law.¹⁷⁰

E. New Initiatives: A Paradigm Shift at the International Level

The existing treaties and standards related to mental disability form an inconsistent patchwork of legal protections for persons with mental disabilities. Nonetheless, these existing instruments cede substantial authority to international bodies to enforce disability rights. Historically, international treaty monitoring bodies have not made significant efforts to protect and enforce mental health rights, even though existing treaty rights amply cover the rights of persons with mental disabilities.¹⁷¹ Recently, new efforts have been undertaken at the international level to advance disability rights and supply supplementary guidance to national governments seeking to understand and enforce these rights. Two important initiatives are the historic effort to draft a binding international convention on disabilities and the development of a mental health legislation manual by the World Health Organization (WHO).¹⁷²

168. *Id.* at 288.

169. The Inter-American Commission, for example, has explicitly recognized the MI Principles. Victor Rosario Congo v. Ecuador, Case 11.427, Inter-Am. C.H.R. 63/99, para. 54 (1999), <http://www.cidh.oas.org/annualrep/98eng/Merits/Ecuador%2011427.htm>.

170. In their introduction, the Standard Rules contemplate the possibility of becoming customary international law: "Although the Rules are not compulsory, they can become international customary rules when they are applied by a great number of States with the intention of respecting a rule in international law." *Standard Rules*, G.A. Res. 96, *supra* note 66, at Introduction, para. 14, [1993] 47 U.N.Y.B. at 979.

171. See, e.g., Quinn, *supra* note 97, at 1 (finding that "United Nations human rights treaty bodies have considerable potential . . . but have generally been underused in advancing the rights of persons with disabilities"); see also Rosenthal & Sundram, *supra* note 30, at 468-70 (noting that reports from Special Rapporteurs and NGOs consistently demonstrate a severe lack of enforcement of existing human rights laws on behalf of persons with mental disabilities); Philip Alston, *Disability and the International Covenant on Economic, Social and Cultural Rights*, in HUMAN RIGHTS AND DISABLED PERSONS: ESSAYS AND RELEVANT HUMAN RIGHTS INSTRUMENTS 94 (Theresia Degener & Yolan Koster-Dreese eds., 1995) ("International human rights forums have been generally unresponsive to the situation and specific needs of persons with disabilities.").

172. See Rosenthal & Sundram, *supra* note 30, at 473-74 (describing attempts to draft a disability convention); see *WHO Project*, *supra* note 31 (discussing the development of the Manual on Mental Health Legislation).

After years of inaction, in 2001, the United Nations General Assembly established an Ad Hoc Committee “to consider proposals for a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities.”¹⁷³ While disability advocates championed the merits of a specific convention addressing disability rights as far back as the Despouy report, the creation of the Ad Hoc Committee represents a potential paradigm shift in the United Nations system.¹⁷⁴ The passage of a disability convention would create a binding treaty at the international level that would support existing disability rights instruments without undermining them.¹⁷⁵

The consideration of a thematic treaty on disability will likely have a considerable effect on the protection of disability rights in the United Nations system regardless of whether it is enacted. The proceedings of the Ad Hoc Committee will necessarily examine the coverage of disability rights under existing treaties and use these precedents to construct the new convention.¹⁷⁶ However, new instruments do not inherently advance human rights. Under some circumstances, a new instrument can actually reduce human rights protections compared with existing international law if it includes lax enforcement provisions or uses antiquated and disempowering terminology.¹⁷⁷

The World Health Organization is currently working on a Mental Health Legislation Manual (the WHO Manual) and related materials that will review and analyze legal provisions at the national level.¹⁷⁸ The WHO Manual represents an important approach by the international community to seriously explore the application of human rights to issues of mental health. Instead of establishing standards through international treaties and commissions, the WHO Manual seeks to

173. Comprehensive and Integral Convention to Promote and Protect the Rights and Dignity of Persons with Disabilities, G.A. Res. 168, U.N. GAOR, 56th Sess., 88th plen. mtg., U.N. Doc. A/56/583/Add.2 (2001).

174. Quinn, *supra* note 97, at 29.

175. *Id.* at 182-83. The drafting process is ongoing as of this writing and will likely take several years.

176. *Id.* at 181-82.

177. See Rosenthal & Sundram, *supra* note 30, at 474-75 (noting that the drafters of the Inter-American Convention on the Elimination of All Forms of Discrimination on the Basis of Disability undermined its enforceability by requiring States to eliminate discrimination “gradually” without defining this term).

178. WORLD HEALTH ORGANIZATION, WHO MANUAL ON MENTAL HEALTH LEGISLATION, available at http://www.cct-freiburg.de/who/human_rights/documents/legmanualfactsheet.pdf (last visited Nov. 8, 2003). The WHO Manual is currently under revision and WHO likely will release it in 2004.

provide guidance on national legislation without the imprimatur of an international mandate.¹⁷⁹ While the WHO Manual will seek to incorporate many of the human rights provisions recognized in the MI Principles and Standard Rules, the focus will be on incorporating these concepts into domestic legislation.¹⁸⁰

Given the disparate approaches to mental health practice around the world and the varying capacity of mental health laws at the national level to govern these practices, the WHO Manual will serve as a useful template for systematically addressing existing deficiencies in national mental health laws.¹⁸¹ The WHO Manual will also help governments update their respective national mental health laws to reflect modern mental health practice and respect human rights norms.¹⁸² The WHO Manual will address policy and implementation issues as well as the contents of the legal framework, and will include best practice suggestions from existing national laws.¹⁸³

The framework for establishing the rights of persons with mental disabilities within the United Nations system continues to progress. Ongoing initiatives, such as the proposed disability convention and the WHO Manual, represent a growing commitment to the further development of clear and effective human rights for persons with mental disabilities in the international system. Even if the new disability convention does not come to fruition, the existing structure of international instruments and standards provides a substantial collection of rights and fundamental freedoms that can be invoked for the protection and benefit of persons with mental disabilities.¹⁸⁴ It is imperative that the development of these existing instruments continues concurrently with the new initiatives. Similarly, international treaty monitoring bodies must recognize the importance of mental disability rights, and be willing to enforce these rights when violations occur.¹⁸⁵ The renewed appointment of a Special Rapporteur on Disa-

179. See WHO Project, *supra* note 31 ("The Manual will serve as the basis for . . . providing step-by-step guidance on developing and implementing mental health legislation.").

180. See *id.*

181. See *id.* (noting that the objective of the Manual is to "inform and assist countries wishing to formulate legislation").

182. See *id.*

183. *Id.*

184. See Rosenthal & Sundram, *supra* note 30, at 491 (noting that although "a broad array of international human rights protections do exist under existing international human rights conventions, a new disability rights convention that spells out these rights in detail would greatly aid compliance by clearly notifying governments as to their international obligations").

185. See Rosenthal & Rubenstein, *supra* note 29, at 283-84 (stating that international human rights monitoring can help create customary international law).

bility signals that there is continuing support for disability rights enforcement at the international level.¹⁸⁶ International institutions should heed the call of Special Rapporteur Bengt Lindqvist to pay special attention to developmental and psychiatric disabilities under current treaty provisions in addition to developing new provisions.¹⁸⁷

The next part of this Article discusses the development and evolution of important treaty obligations and institutions under regional human rights systems.

III. REGIONAL SYSTEMS FOR THE PROTECTION OF HUMAN RIGHTS

Regional human rights systems provide additional opportunities for the protection and development of human rights at the supranational level. These regional systems have developed concurrently with the international human rights institutions of the United Nations and share many of the ideals and goals of the United Nations system.¹⁸⁸ However, the regional nature of these systems has allowed for the creation and implementation of novel approaches and institutions to protect and promote human rights.¹⁸⁹ Europe, Africa, and the Americas have all developed regional human rights systems.¹⁹⁰ Other regions of the world have considered regional human rights systems, but have not yet finalized or implemented these arrangements.¹⁹¹

While there is a general consensus that human rights are universal, regional systems have created additional fora for the protection and promotion of human rights, often through more direct means.¹⁹² Courts and commissions established at the regional level have granted individuals the ability to redress human rights grievances that have

186. See United Nations Enable, *supra* note 156.

187. See *Second Mission*, *supra* note 157, paras. 107-111, 118, 149; *Third Mandate*, *supra* note 157, paras. 38-75.

188. See Arlene S. Kanter, *The Globalization of Disability Rights Law*, 30 SYRACUSE J. INT'L L. & COM. 241, 241-44 (2003) (describing the "confluence" of regional and international efforts to protect human rights for those with disabilities).

189. See *id.* at 249-53 (discussing differences among nations' approaches, such as various definitions of disability, different models with which to frame rights, and unique remedies).

190. Rosenthal & Sundram, *supra* note 135, at 473.

191. The Arab Charter on Human Rights, adopted by the League of Arab States on September 15, 1994, has not yet come into force and is essentially dormant at the time of this writing. *Arab Charter on Human Rights*, adopted Sept. 15, 1994, reprinted in 18 HUM. RTS. L.J. 151 (1997). There is no comparable human rights system in Asia, although an Asian regional human rights system has been proposed. See STEINER & ALSTON, *supra* note 19, at 779-80.

192. Kanter, *supra* note 188, at 259-60.

not been dealt with appropriately at the domestic level or to challenge domestic policies and practices that violate human rights norms.¹⁹³

A. *European System for the Protection of Human Rights*

On May 10, 1948, delegates to the Congress of Europe in the Hague said: "We desire a Charter of Human Rights guaranteeing liberty of thought, assembly and expression as well as the right to form a political opposition."¹⁹⁴ The following year, Article 3 of the Statute of the Council of Europe (which formed the Council) affirmed "the principles of the rule of law and of the enjoyment by all persons . . . of human rights and fundamental freedoms."¹⁹⁵ This began a process that culminated in the signing of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) in Rome on November 4, 1950.¹⁹⁶ The United Kingdom was the first country to ratify the Convention on March 8, 1951 and, by 1974, all eighteen then existing States of the Council had ratified it.¹⁹⁷ Today, the Council has more than forty Members.¹⁹⁸

Until recently, member states of the Council of Europe were not obliged to permit individual litigants access to the two institutions cre-

193. *Id.*

194. A.H. ROBERTSON, HUMAN RIGHTS IN EUROPE 6 (2d ed. 1977).

195. Statute of the Council of Europe, May 5, 1949, chap. 2, art. 3, Europ. T.S. No. 1.

196. ECHR, *supra* note 35. The ECHR was modeled on the UDHR. FRANCIS G. JACOBS, THE EUROPEAN CONVENTION ON HUMAN RIGHTS 4 (1975).

197. JACOBS, *supra* note 196, at 2 n.1.

198. As of this writing, there are 45 members of the Council of Europe. Permanent Representatives of the Council of Europe, at <http://cm/coe.int/who.2.htm> (last visited Nov. 8, 2003). The European Union (which is a separate entity from the Council of Europe) is not a party to the Convention, and the Union does not accede to its authority. See Case 2/94, 1996 E.C.R. I-1759. While European Union law does not provide a major vehicle for human rights adjudication, Article F(2) of the Treaty on European Union 1992 (the Maastricht Treaty), does contain a nonjusticiable provision relevant to human rights: "The Union shall respect fundamental rights, as guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms . . ." TREATY ON EUROPEAN UNION, art. F(2), July 29, 1992, O.J. (C 191) (1992). Additionally, after the Amsterdam amendment in 1997, the Treaty Establishing the European Communities now contains provisions on discrimination and public health. 2002 O.J. (C325) 33. Article 13 of the Treaty enables the European Community (EC) to "take appropriate action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age, or sexual orientation." *Id.* art. 13, 2002 O.J. at 43. Article 152 (formerly Article 129 of the Maastricht Treaty) states that "a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities." *Id.* art. 152, 2002 O.J. at 100. Consequently, European Union law, while certainly relevant, does not offer the kind of adjudicative power on mental health and human rights as does the Council of Europe. See generally Dinah Shelton, *The Boundaries of Human Rights Jurisdiction in Europe*, 13 DUKE J. COMP. & INT'L L. 95 (2003) (examining questions and concerns presented by the overlapping human rights jurisdictions of regional legal systems in Europe).

ated by the ECHR—the Commission and Court—to redress violations of rights and freedoms, although most chose to do so.¹⁹⁹ The Eleventh Protocol to the ECHR, which entered into force on November 1, 1998, merged the functions of these two institutions into a single European Court of Human Rights (European Court).²⁰⁰ The European Court's jurisdiction pursuant to the Protocol extends to all matters concerning the interpretation and application of the ECHR.²⁰¹ Further, with the passage of the Protocol, the ability of individuals to apply directly to the European Court became a right upon which contracting parties could no longer impede.²⁰² Therefore, in addition to its mandatory jurisdiction over inter-state cases,²⁰³ the European Court hears individual applications by persons or nongovernmental organizations who are "victim[s]" of a violation of human rights by a contracting party.²⁰⁴

199. The United Kingdom, for example, granted the right of individual petition in 1966. The United Kingdom Home Department, *Rights Brought Home: The Human Rights Bill*, para. 1.2 (1997), available at <http://www.archive.official-documents.co.uk/document/hoffice/rights/rights.htm>. Many states, however, did incorporate the ECHR into domestic law so that citizens could present human rights claims to their own courts. France, for example, incorporated the ECHR into domestic law soon after the Convention was ratified, but the United Kingdom took no action until the close of the Twentieth Century. Human Rights Act, 1998, c. 42 (Eng.).

200. ECHR, *supra* note 35, art. 19. Previously, the European Commission of Human Rights (European Commission) received all applications, having the power to find them "inadmissible" or "admissible." Kevin Boyle, *Practice and Procedure on Individual Applications Under the European Convention on Human Rights*, in GUIDE TO INTERNATIONAL HUMAN RIGHTS PRACTICE, *supra* note 63, at 135. If the Commission found an application "admissible" it investigated and sought a "friendly settlement." *Id.* It also had power to report to the Committee of Ministers and to refer cases to the European Court. *Id.* at 135-37. The European Court had, and continues to have, the ultimate power to adjudicate violations of the ECHR. *Id.* at 135; ECHR, *supra* note 35, art. 44.

201. ECHR, *supra* note 35, art. 32(1). The European Court considers cases by sitting on committees of three judge panels, in seven judge Chambers, and in a seventeen judge Grand Chamber. *Id.* art. 27(1). The Court can consider cases only after the plaintiff has exhausted all domestic remedies and if less than six months has passed since the date on which a domestic court made its final decision. *Id.* art. 35(1). The European Court can hold an application "inadmissible" if it is "incompatible" with the Convention (e.g., the Convention does not apply), "manifestly ill-founded" (e.g., the facts do not disclose a prima facie violation), or an "abuse of the right of application" (e.g., politically motivated). *Id.* art. 35(3). If the European Court finds the case "admissible," it will investigate the case and try to negotiate an agreement between the parties or it will hold a hearing and render a decision on the merits. *Id.* art. 38(1). If it finds a violation of the ECHR, the European Court has the power to give the injured party "just satisfaction" (i.e., damages and reimbursement of legal costs). *Id.* art. 41. An injured party can appeal a Chamber's judgment to the Grand Chamber if the decision raises a serious issue that affects the interpretation of the ECHR or one that is of general importance. *Id.* art. 43(1)-(2).

202. *Id.* art. 34.

203. *Id.* art. 33.

204. *Id.* art. 34.

The right of individuals to bring human rights violations directly to the European Court has rendered the European System amenable to the protection of human rights of persons with mental disabilities by allowing these individuals access to an alternative legal venue when domestic protections are inadequate.²⁰⁵ Moreover, many of the member countries of the Council of Europe have incorporated the ECHR into their domestic law, providing domestic courts with the opportunity to refine and expand the theory and practice of human rights.²⁰⁶

B. Inter-American System for the Protection of Human Rights

The Inter-American System for the Protection of Human Rights resides within the jurisdiction of the Organization of American States (OAS).²⁰⁷ Human rights in this system are protected under several multilateral treaties. The American Declaration of the Rights and Duties of Man (American Declaration), adopted by the OAS in 1948, contains comparable provisions to the UDHR and includes civil and political rights and economic, social, and cultural rights.²⁰⁸ The OAS, through a resolution, also established the Inter-American Commission on Human Rights (Inter-American Commission) to monitor and report on compliance of member states with the rights protected in the Declaration.²⁰⁹ Despite subsequent efforts to define the jurisdiction

205. *See id.*

206. For example, in the United Kingdom, state obligations under international law were not part of domestic law or effectively justiciable by domestic courts prior to the passage of the Human Rights Act of 1998. Human Rights Act, 1998, c. 42 (Eng.). Other commentators have detailed the role of human rights law in the United Kingdom prior to the 1998 Act. *See* OLIVER THOROLD, MENTAL HEALTH LAW AND HUMAN RIGHTS ACT OF 1998 (2000); MURRAY HUNT, USING HUMAN RIGHTS LAW IN ENGLISH COURTS (1997); RABINDER SINGH, THE FUTURE OF HUMAN RIGHTS IN THE UNITED KINGDOM (1997). Since enactment of the Human Rights Act, British courts have decided a number of cases on human rights grounds relevant to persons with mental disabilities, and many more are expected. *See, e.g.,* Regina v. London N. & E. Region Mental Health Review Tribunal, 3 W.L.R. 512, 522 (2001) (discussing section 10 of the Human Rights Act).

207. Christina Cerna, *The Inter-American Commission on Human Rights: Its Organization and Examination of Petitions and Communications*, in INTER-AMERICAN SYSTEM, *supra* note 33, at 65, 66.

208. Inter-American Commission on Human Rights, American Declaration of the Rights and Duties of Man (1948), available at <http://www.cidh.oas.org/Basicos/basic2.htm> (last visited Oct. 7, 2003) [hereinafter American Declaration]. The American Declaration was actually adopted three months before the UDHR, giving it the distinction of being the first detailed exposition of human rights promulgated by an intergovernmental organization. *See* Tom Farer, *The Rise of the Inter-American Human Rights Regime: No Longer a Unicorn, Not Yet an Ox*, in INTER-AMERICAN SYSTEM, *supra* note 33, at 31, 35 (noting that although the UDHR is the most celebrated text of international human rights, the American Declaration has the honor of being the "first broadly detailed enumeration of rights . . . adopted by an intergovernmental organization").

209. Farer, *supra* note 208, at 35-36.

of the Inter-American Commission,²¹⁰ its role and power remained vague until the drafting of the American Convention on Human Rights (American Convention) in 1969.²¹¹

The American Convention expanded and clarified the rights described in the American Declaration and authorized the Inter-American Commission and the newly formed Inter-American Court of Human Rights (Inter-American Court) to enforce these rights.²¹² The American Convention emphasizes civil and political rights—it only references economic, social, and cultural rights in a general manner, stating that national governments should attempt to progressively achieve this set of rights.²¹³ The more recently enacted Protocol on Economic, Social and Cultural Rights contains a more expansive treatment of economic, social, and cultural rights, but the Inter-American Commission has limited jurisdiction over rights under this Protocol.²¹⁴

Pursuant to the American Convention, the Inter-American Commission has jurisdiction to issue country reports and to examine individual petitions alleging human rights violations.²¹⁵ The Inter-American Court has advisory and contentious jurisdiction.²¹⁶ Advisory jurisdiction permits the Inter-American Court to issue advisory opinions interpreting issues of human rights law at the request of OAS states.²¹⁷ Contentious jurisdiction allows the Court to adjudicate

210. See Protocol of Amendment to the Charter of the Organization of American States, *opened for signature*, Feb. 27, 1967, art. 112, O.A.S. T.S. No. 1-A (entered into force Mar. 12, 1970) (stating that the principal function of the Inter-American Commission is to promote human rights and to serve as consultant to the OAS regarding human rights).

211. American Convention, *supra* note 68, 9 I.L.M. 673.

212. *Id.* arts. 41, 61-65, 9 I.L.M. at 686, 691-92.

213. *Id.* arts. 26, 42, 9 I.L.M. at 683, 686.

214. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, *adopted* Nov. 17, 1988, *available at* <http://www.cidh.oas.cas.org/Basicos/basic5.htm> [hereinafter Additional Protocol]; *see also* Matthew Craven, *The Protection of Economic, Social, and Cultural Rights Under the Inter-American System of Human Rights*, in INTER-AMERICAN SYSTEM, *supra* note 33, at 289, 307-11 (noting the expansion and recognition of certain rights by the Protocol on Economic, Social and Cultural Rights, such as the right to food, the right to a healthy environment, the right to the formation and protection of a family, the rights of children, the protection of the elderly, and the protection of the handicapped). The Inter-American Commission may only accept individual petitions for certain rights violations, such as violations of the right to form trade unions and the right to education. Additional Protocol, *supra*, art. 19(6). Instead, the Inter-American Economic and Social Council has oversight responsibilities. *Id.* art. 19.

215. American Convention, *supra* note 68, arts. 41(c), 44, 9 I.L.M. at 686-87.

216. *Id.* art. 64(2), 9 I.L.M. at 692.

217. *Id.*; *see also* Jo M. Pasqualucci, *Advisory Practice of the Inter-American Court of Human Rights: Contributing to the Evolution of International Human Rights Law*, 38 STAN. J. INT'L L. 241, 242-43 (2002) (describing the Inter-American Court's advisory jurisdiction as a

claims of human rights violations by state parties, provided that the state parties have explicitly recognized the jurisdiction of the Inter-American Court.²¹⁸

More recently, the OAS adopted the Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities.²¹⁹ This Convention aims to eliminate all forms of discrimination against persons with disabilities, including those with mental disabilities, and encourages states to make efforts toward completely integrating persons with disabilities into society.²²⁰ Notably, the Convention explicitly links protection from discrimination and community integration.²²¹ Nevertheless, some commentators have been critical of the scope and language used in the Convention.²²² While this Convention has not yet gone into effect, it holds great promise for promoting the human rights of persons with mental disabilities in the Americas.

C. *African System for the Protection of Human Rights*

The development of a regional human rights system in Africa has proceeded more gradually than development in other regional systems. The more protracted pace of regional human rights development in Africa stems from the historical exploitation of Africans by non-Africans during the colonial period, which resulted in a preference for strong state sovereignty rights and a corresponding reluctance to interfere with internal state affairs.²²³ The Organization for African Unity, formed in 1963, did not draft a human rights instru-

method of crystalizing the purpose and meaning of international human rights and providing judicial interpretation of the issues submitted by requesting parties).

218. American Convention, *supra* note 68, art. 62, 9 I.L.M. at 691-92; *see also* Antônio Augusto Cançado Trindade, *The Operation of the Inter-American Court of Human Rights*, in INTER-AMERICAN SYSTEM, *supra* note 33, at 133, 135 (emphasizing that the contentious jurisdiction of the Inter-American Court is predicated on a state having recognized the Court's jurisdiction either by a special declaration or agreement).

219. Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons With Disabilities, *adopted* June 7, 1999, *available at* <http://www.cidh.oas.org/basicos/disability.htm>.

220. *Id.* art. II.

221. *Id.* art. IV.

222. *See, e.g.*, Rosenthal & Sundram, *supra* note 30, at 474-75 (criticizing the drafters' choice of language in Article III(1), which allows states to eliminate discrimination "gradually," because the term "gradually" could be used by states to avoid taking immediate action in dealing with discrimination).

223. *See* VINCENT O. ORLU NMEHIELLE, *THE AFRICAN HUMAN RIGHTS SYSTEM* 67-69 (2001) (attributing Africa's late participation in the promotion and protection of international human rights to its focus on eradicating colonialism within its borders and its belief that human rights are internal issues that an outside body should not address).

ment until nearly twenty years after its founding.²²⁴ That instrument, the African (Banjul) Charter on Human and Peoples' Rights (African Charter), forms the centerpiece of the African Human Rights System.²²⁵ Much like the organs of its European and Inter-American counterparts, the Charter guarantees civil and political human rights and provides for the establishment of an African Commission on Human and Peoples' Rights (African Commission) to promote, protect, and interpret these rights.²²⁶ The African Charter contains civil and political rights, economic, social, and cultural rights, and "peoples' rights"—an additional human rights concept that distinguishes community rights as a separate and compelling regional concern.²²⁷

The African Charter differs from other regional instruments in two other ways. First, in addition to the rights granted, it contains a corresponding list of individual duties.²²⁸ Second, the African Charter appears to grant state parties more latitude in their compliance with Charter rights.²²⁹ The African Charter does not contain a specific derogation clause, and the African Commission has refused to allow states to derogate rights, even in an emergency situation.²³⁰ However, the Charter includes general limitation clauses, internal limitation clauses, and broadly worded "claw-backs"—provisions that a state might interpret to allow it to claim any act as an exception to rights found in the Charter if mandated by national or sub-national law.²³¹ Nevertheless, the Commission has interpreted the claw-back

224. Gino J. Naldi, *Future Trends in Human Rights in Africa: The Increased Role of the OAU?*, in *THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS: THE SYSTEM IN PRACTICE*, 1986-2000, at 1, 1 (Malcolm D. Evans & Rachel Murray eds., 2002) [hereinafter *AFRICAN CHARTER IN PRACTICE*].

225. African Charter, *supra* note 68, 21 I.L.M. at 58. All member states of the OAU have ratified the African Charter. Naldi, *supra* note 224, at 5 n.28.

226. African Charter, *supra* note 68, arts. 1-24, 30, 21 I.L.M. at 60-64.

227. *Id.* arts. 1-24, 21 I.L.M. at 60-63; see NMEHIELLE, *supra* note 223, at 138-39 (explaining the concept of "peoples' rights").

228. African Charter, *supra* note 68, arts. 27-29, 9 I.L.M. at 63. The duties include preservation of the family, refraining from discrimination, paying taxes, serving your country, and promoting African unity. *Id.* The American Declaration also enumerates individual duties, but the American Convention did not incorporate these duties. American Declaration, *supra* note 208, arts. XXIX-XXXVIII.

229. See Christof Heyns, *Civil and Political Rights in the African Charter*, in *AFRICAN CHARTER IN PRACTICE*, *supra* note 224, at 137, 139 (describing the African Charter's failure to provide specific procedures for states to follow in times of war or natural disasters as a weakness because the absence of any provision essentially allows a state to disregard the African Charter during such times).

230. *Id.* (noting that the African Commission has made several rulings that states cannot use emergency situations to justify derogating rights).

231. *Id.* at 142; see African Charter, *supra* note 68, art. 9(2), 21 I.L.M. at 60 ("Every individual shall have the right to express and disseminate his opinions *within the law*.") (empha-

provisions to apply to international law rather than municipal or national law, therefore reducing the chance that governments can use these provisions to undermine the effectiveness and universality of the rights in the African Charter.²³²

The African Charter created the African Commission.²³³ The African Commission has the power to investigate violations of the rights in the African Charter and to collect state reports detailing compliance with the Charter.²³⁴ More importantly, the African Commission has implemented a communications procedure whereby it receives complaints or petitions from member states or other parties alleging violations of human rights.²³⁵ The African Commission has interpreted its communications jurisdiction quite liberally—individuals, groups, and NGOs can file complaints, regardless of their geographical location and whether or not the petitioner is actually a victim of the alleged violation.²³⁶ By contrast, the Inter-American Commission allows complaints from individuals and NGOs, but only NGOs that have been legally recognized by the Inter-American Commission's member states.²³⁷ The European System allows complaints only from petitioners and NGOs who are actual victims of the alleged violation and within the jurisdiction of the state.²³⁸ Despite this more accommodating approach in the African system, individuals and NGOs have infrequently utilized this procedure.²³⁹ The African Commission issues recommendations in response to communications, but the enforcement of substantive remedies based upon the Commission's determinations has been problematic.²⁴⁰

sis added); *see id.* art. 10(1), 21 I.L.M. at 61 ("Every individual shall have the right to free association *provided that he abides by the law.*") (emphasis added). As these examples show, the claw-back provisions could allow a state to eviscerate the meaning of the rights based upon their interpretation of "the law." *See* Heyns, *supra* note 229, at 142.

232. *See* Communication 101/93, *Civil Liberties Organisation v. Nigeria*, Eighth Activity Report 1994-1995, Annex VI (*Documents of the African Commission*, at 394) paras. 15-16 (interpreting Article 10 of the African Charter to prohibit governments from enacting laws that interfere with an individual's right to free association or conflict with international human right standards), <http://www.umn.edu/humanrts/Africa/comcases/101-93.html>; Heyns, *supra* note 229, at 142.

233. African Charter, *supra* note 68, art. 30, 21 I.L.M. at 63-64.

234. *Id.* arts. 46, 62, 21 I.L.M. at 65, 68.

235. *Id.* arts. 47-59, 21 I.L.M. at 65-67.

236. Frans Viljoen, *Admissibility Under the African Charter*, in *AFRICAN CHARTER IN PRACTICE*, *supra* note 224, at 61, 74-76.

237. American Convention, *supra* note 68, art. 44-47, 9 I.L.M. at 687-88.

238. ECHR, *supra* note 35, art. 34.

239. NMEHIELLE, *supra* note 223, at 197, 204-05.

240. *Id.* at 239.

The relative successes of the Inter-American and European human rights systems have demonstrated the effectiveness of judicial courts in articulating international legal principles at the regional level. In 1998, the OAU approved the African Court of Human Rights (African Court), with the intention of strengthening human rights protection and enforcement within the African System.²⁴¹ The African Court, when established,²⁴² will have contentious and advisory jurisdiction over allegations of human rights violations under the African Charter.²⁴³ The jurisdictional relationship between the African Commission and Court is not completely clear, but the African Court will likely become the predominant institution for protecting human rights on the continent.²⁴⁴ In contrast to the African Commission, the African Court will possess adjudicatory powers and will have the authority to issue legal decisions and mandate remedies.²⁴⁵ However, individuals and NGOs will only be able to petition directly to the Court if state parties assent to the African Court's jurisdiction.²⁴⁶

IV. DEVELOPMENT OF HUMAN RIGHTS FOR PERSONS WITH MENTAL DISABILITIES UNDER REGIONAL HUMAN RIGHTS SYSTEMS

The level of jurisprudential and interpretive development varies greatly between the three regional human rights systems. There exists an extensive body of case law on mental health from the European Commission and Court of Human Rights and an impressive body of scholarship interpreting the application of its jurisprudence to per-

241. Protocol to the African Charter on Human and Peoples' Rights on the Establishment of African Court on Human and Peoples' Rights, *adopted* June 9, 1988, arts. 1-2, *available at* http://www.acdhrs.org/African_Court.doc [hereinafter African Court Protocol].

242. Five years after its adoption, the African Court Protocol establishing the Court has yet to enter into force. Article 34 of the African Court Protocol states that it will come into force after fifteen instruments of ratification or accession have been deposited with the Secretary-General of the OAU. *Id.* art. 34. As of September 2002, only the following six States have ratified the Protocol: Burkina Faso, Gambia, Mali, Senegal, South Africa, and Uganda. African Centre for Democracy and Human Rights Studies, Status of Ratification of the Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights, *available at* http://www.acdhrs.org/African_Court.doc (last visited Sept. 14, 2003).

243. African Court Protocol, *supra* note 241, arts. 3-5.

244. *See* NMEHIELLE, *supra* note 223, at 261-63 (noting that, despite the African Court Protocol's failure in Article 2 to state with specificity the relationship between the Court's and the Commission's functions, the power conferred to the Court by Article 3 to interpret and apply the African Charter, the Protocol, and other human rights agreements guarantees that the Court will be highly influential).

245. African Court Protocol, *supra* note 241, arts. 26-30.

246. *See* NMEHIELLE, *supra* note 223, at 270 (discussing the ability of individuals and NGOs to petition the African court).

sons with mental disabilities.²⁴⁷ By contrast, the institutions of the Inter-American and African systems have historically exhibited far less interest in addressing mental health issues.²⁴⁸ This variation may be a result of the different structural components of the respective systems or an indication of the distinct regional political, economic, and cultural complexities.²⁴⁹ Legal developments within the European System have even been looked upon approvingly as precedent by the other regional systems.²⁵⁰ The European Human Rights System has thus far dealt with human rights that are predominantly civil and political in character. That is, the courts have placed limits on governmental interference with rights and freedoms, rather than establishing a positive entitlement to government services.²⁵¹ The re-

247. See Phillip Fennell, *The Third Way in Mental Health Policy: Negative Rights, Positive Rights, and the Convention*, 26 J.L. & Soc'y 103, 105-27 (1999) (discussing the European Court of Human Rights' development of mentally disabled patients' right to receive a minimum standard of service); Thorold, *supra* note 206, at 619 (assessing United Kingdom mental health law in light of the requirements of the European Convention on Human Rights); David Hewitt, *Mental Health Law, in HUMAN RIGHTS ACT 1998: A PRACTITIONER'S GUIDE* 311 (Christopher Baker ed., 1998) (examining the application of the Human Rights Act 1998 in various court cases); T.W. Harding, *The Application of The European Convention of Human Rights to the Field of Psychiatry*, 12 INT'L J.L. & PSYCHIATRY 245, 250-62 (1989) (analyzing various complaints filed under the European Convention of Human Rights involving individuals unlawfully detained and subjected to psychiatric examination and those who are mentally ill).

248. See, e.g., NMEHIELLE, *supra* note 223, at 204-05 (stating that on the tenth anniversary of the African Commission, it had received only 202 complaints and communications from individuals).

249. The lack of mental health cases before the Inter-American and African Systems may be attributable to political instability in many nations in these regions. See Nsongurua J. Udombana, *Toward the African Court on Human and Peoples' Rights: Better Late Than Never*, 3 YALE HUM. RTS. & DEV. L.J. 45, 50-54 (2000) (describing the effect of unstable political conditions on human rights in Africa). The regional institutions have, thus, concentrated on the most serious human rights violations, such as extrajudicial killings, violent political repression, and subversion of the rule of law. *Id.*; see also Farer, *supra* note 208, at 42-46 (explaining how incessant coups, civil wars, and political instability over a 20-year period undermined the development of a human rights system in the Americas).

250. See, e.g., Victor Rosario Congo v. Ecuador, Case 11.427, Inter-Am. C.H.R. 63/99, para. 66 (1999), <http://www.cidh.oas.org/annualrep/98eng/Merits/Ecuador%2011427.htm> (citing the European Commission's holding in *Herczegfalvy v. Austria*, in which the Commission ruled that it may be considered inhumane to hold a mentally disabled person in wretched conditions and without medical treatment); see also David Harris, *Regional Protection of Human Rights: The Inter-American Achievement*, in INTER-AMERICAN SYSTEM, *supra* note 33, at 5-6 (noting instances where the Inter-American Commission and Court of Human Rights have cited to and followed precedent from the European System); Rosenthal & Rubenstein, *supra* note 29, at 273 n.119 (stating that case law within the European System is relevant to the Inter-American System because the Inter-American System is closely modeled after the European System).

251. See JACOBS, *supra* note 196, at 4 (comparing economic, social, and cultural rights, requiring action by the state with civil and political rights, and requiring protection against state action).

spective regional bodies within the Inter-American and African Systems, which have developed their human rights jurisprudence to a lesser extent, have similarly focused on civil and political rights.²⁵² The case law can be categorized into three primary areas: compulsory detention, conditions of confinement, and civil rights.

*A. Involuntary Admission and Subsequent Detention
in Mental Institutions*

The regional human rights systems guarantee the right to liberty and security of the person.²⁵³ Under the European System, these rights are found within Article 5.²⁵⁴ Article 5(1) of the ECHR lists the circumstances in which governments may justifiably deprive persons of their liberty and includes a provision referring to “persons of unsound mind.”²⁵⁵ The Inter-American and African instruments provide similarly strong liberty protections, but list only general justifications for deprivation of liberty.²⁵⁶ Governments must inform persons of the reasons for their arrest (including “psychiatric” arrest) under the European²⁵⁷ and American²⁵⁸ Systems. The European and American Systems also require governments to provide a “speedy” review of the detention by an independent court or tribunal.²⁵⁹ Finally, victims of arrest or detention in contravention of the ECHR or American Convention must have an enforceable remedy in damages.²⁶⁰

1. *The Meaning of “Detention” in the European System.*—The entire framework for protecting liberty and security of the person depends on whether government is “detaining” a person with mental disability. If government is not “detaining” a person, then the considerable safe-

252. NMEHIELLE, *supra* note 223, at 58.

253. American Convention, *supra* note 68, art. 7(1), 9 I.L.M. at 677; African Charter, *supra* note 68, art. 6, 21 I.L.M. at 60; ECHR, *supra* note 35, art. 5(1).

254. ECHR, *supra* note 35, art. 5(1).

255. *Id.* art. 5(1)(e).

256. American Convention, *supra* note 68, art. 7(2), 9 I.L.M. at 677 (“No one shall be deprived of his physical liberty except for the reasons and under the conditions established beforehand by the constitution of the State Party concerned or by a law established pursuant thereto.”); African Charter, *supra* note 68, art. 6, 21 I.L.M. at 60 (“No one may be deprived of his freedom except for reasons and conditions previously laid down by law.”).

257. ECHR, *supra* note 35, art. 5(2).

258. American Convention, *supra* note 68, art. 7(4), 9 I.L.M. at 677.

259. ECHR, *supra* note 35, art. 5(4) (the lawfulness of a detention shall be decided “speedily”); American Convention, *supra* note 68, art. 7(6), 9 I.L.M. at 677 (the court shall decide on the lawfulness of a detention “without delay”).

260. ECHR, *supra* note 35, art. 5(5); American Convention, *supra* note 68, art. 10, 9 I.L.M. at 679.

guards of Article 5 of the ECHR do not apply.²⁶¹ On its face, one could read the language of Article 5 quite liberally: "Everyone has the right to liberty and security of person."²⁶² Since personal security is a concept broader than liberty, the language implies that Article 5 concerns itself with all instances of the government constraining a person's liberty.²⁶³

Despite the possible differences in scope between liberty and security, the European Court construes Article 5 to apply only to cases of formal detention and it appears to see detention mainly as a relatively long period of confinement within an institution.²⁶⁴ The European Court distinguishes detention,²⁶⁵ which triggers Article 5 safeguards, from a mere restriction of movement, which receives decidedly less protection in other parts of the ECHR.²⁶⁶ In examining detention determinations, the European Court considers all of the circumstances of the case, including the type, duration, effects, and manner of the restraint.²⁶⁷ Detention is a matter of "degree or intensity" (not "nature or substance"), with more severe restrictions rising to the level of "detention."²⁶⁸ In *Ashingdane v. United Kingdom*, for example, the European Court held that a patient was detained "in the sense that his liberty, and not just his freedom of movement, [had] been circumscribed both in fact and in law . . . , even though he [had] been permitted to leave the hospital on frequent occasions."²⁶⁹

261. See *Engel v. The Netherlands*, 22 Eur. Ct. H.R. (ser. A) at 25 (1976) (explaining that Article 5(1) condemns the arbitrary deprivation of physical liberty by means of arrest or detention).

262. ECHR, *supra* note 35, art. 5(1).

263. See *id.*

264. See *Amuur v. France*, 1996-III Eur. Ct. H.R. 826, 848 (warning that if the holding of asylum-seekers is prolonged and excessive what would normally constitute a mere restriction of liberty can transform into a violation of Article 5(1) or a deprivation of liberty).

265. Article 5 refers to arrests, detentions and deprivations of liberty: Article 5(1): "No one shall be *deprived of his liberty* save in the following cases"; Article 5(2): "Everyone who is *arrested* shall be informed promptly . . . of the reasons"; Article 5(4): "Everyone who is *deprived of his liberty by arrest or detention* shall be entitled to take proceedings" ECHR, *supra* note 35, arts. 5(1)-(4) (emphasis added).

266. Personal restraint that does not involve deprivation of liberty is governed by Article 2 of Protocol No. 4: "Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement" Protocol No. 4 to the Convention for the Protection of Human Rights and Fundamental Freedoms, *opened for signature* Sept. 16, 1963, at <http://www.echr.coe.int/eng> [hereinafter Protocol No. 4].

267. *Ashingdane v. United Kingdom*, 93 Eur. Ct. H.R. (ser. A) at 6, 19 (1985); *Engel v. The Netherlands*, 22 Eur. Ct. H.R. (ser. A) at 25 (1976); *Guzzardi v. Italy*, 3 Eur. H.R. Rep. 333, 362-63 (1980) (Court report).

268. *Amuur*, 1996-III Eur. Ct. H.R. at 848.

269. *Ashingdane*, 93 Eur. Ct. H.R. (ser. A) at 20. *Ashingdane's* responsible medical officer recommended his transfer from Broadmoor (a psychiatric hospital) to a local hospital and the Home Secretary accepted the recommendation. *Id.* at 9. However, the local au-

This formalistic construction of “detention” may leave persons without substantial human rights protection even when their autonomy and liberty are significantly constrained. Consider two important problems in mental health that involve restraints that may fall outside the scope of Article 5: confinement of nonprotesting patients and compulsory supervision in the community.

a. The Problem of the Detention of “Nonprotesting” Patients.—

The problem of “nonprotesting” patients arises when persons are confined in fact but not under the force of law. This may occur in several different contexts. First, a person may succumb to a show of authority because she does not realize that she is free to resist. For example, in *Guenat v. Switzerland*,²⁷⁰ police officers “invited” an individual whom they believed was acting abnormally to come to the police station.²⁷¹ His behavior, in fact, was caused by medication for a neurological condition, but a psychiatrist, called in by the police, arranged for his compulsory admission to a mental hospital.²⁷² The European Commission decided that his confinement in the police station was not a deprivation of liberty because the police did not exert physical force, and he remained free to leave.²⁷³ This decision failed to consider the person’s true circumstances and whether, in reality, he reasonably felt that his liberty was constrained.

Another illustration of this problem occurs when incompetent patients are “voluntarily” admitted to a mental hospital. In the United Kingdom, for example, persons with mental disabilities can be admitted “informally.”²⁷⁴ Informal patients historically have not received

thority refused to admit him because the trade union of nursing staff had operated a total ban on admission of restricted patients. *Id.* at 9-10. Since the nature and conditions in the two hospitals were “fundamentally different,” Ashingdane argued they were akin to choosing between detention and liberty. *Id.* at 19. The Court rejected the claim, stating that, although there are important differences between the regimes in a special hospital and a local hospital, they are both forms of lawful detention. *Id.* at 19-22; *see also* L. v. Sweden, App. No. 10801/84, 61 Eur. Comm’n H.R. Dec. & Rep. 62, 73 (1988) (“[A] person detained in a psychiatric hospital would clearly still be regarded as ‘deprived of his liberty’ even if he was occasionally allowed to leave the hospital premises.”).

270. App. No. 24722/94, 81-B Eur. Comm’n H.R. Dec. & Rep. 130 (1995).

271. *Id.* at 131.

272. *Id.* at 131-32.

273. *Id.* at 134. The European Commission did not hear his complaint that he had been wrongfully admitted to a mental hospital because he failed to raise it before the lower Federal Court of Geneva. *Id.* at 135.

274. Mental Health Act, 1983, c. 20, § 131 (Eng.). The United Kingdom has addressed the issue of informal admission in a White Paper. Secretary of State for Health, REFORMING THE MENTAL HEALTH ACT, 2000 Cm. 5016-I, *available at* <http://www.doh.gov.uk/mentalhealth/whitepaper1.pdf>. In the White Paper, the UK sets out a new legal framework that will provide safeguards of care for patients who do not have the capacity to

any of the usual procedural and substantive safeguards to ensure they have given legally effective consent and that admission is in their best interests.²⁷⁵ Yet, in *R. v. Bournewood Community and Mental Health NHS Trust, ex parte L*,²⁷⁶ the Judicial House of Lords upheld the practice of informal admission.²⁷⁷ In *Bournewood*, a mental hospital informally admitted an adult with severe learning disabilities after he had harmed himself at a day center.²⁷⁸ The House of Lords held unanimously that the common law doctrine of necessity justified his initial sedation and movement to the hospital.²⁷⁹ The informal admission to the hospital, according to the majority, did not amount to a detention.²⁸⁰

There may be strong grounds for believing that, at least in some circumstances, hospitals detain nonprotesting patients within the meaning of Article 5. Recall that *Ashingdane* was “detained” because his liberty was severely constrained “both in fact and in law.”²⁸¹ The incompetent informal patient’s liberty may be severely constrained in fact—he may not be aware of his right to leave the hospital.²⁸² The patient may also be genuinely constrained in law—if he tries to leave the hospital he may be prevented from doing so.²⁸³ For example, in the United Kingdom, doctors and nurses possess the power to hold informal patients for a period of time necessary to accomplish an involuntary admission to hospital.²⁸⁴ The European Court should pay

consent to treatment. *Id.* at 49. It calls for new legislation to provide for quality care, delivered in an appropriate setting, consistent with the patient’s interests, and without unnecessary deprivation of liberty. *Id.* The safeguards will apply to patients admitted to a hospital, an assisted care facility, or a similar establishment. *Id.* Upon admission, a “social care representative” will nominate an advocate who will act on behalf of the patient. *Id.* at 50. A clinical supervisor will assess the patient’s needs and within 28 days develop a final care plan in conjunction with two physicians. *Id.* At any time, either the patient or the advocate may challenge the detention or the care plan and request a Tribunal review of actions taken. *Id.*

275. See Mental Health Act, 1983, at § 131. *But see* REFORMING THE MENTAL HEALTH ACT, *supra* note 274, at 49 (announcing the government’s intention to introduce safeguards for patients treated without the use of compulsory powers). The Department of Health estimated that at any time there may be as many as 44,000 people informally admitted to a hospital with serious, long-term mental incapacity. *Id.*

276. 3 All E.R. 289 (H.L. 1998).

277. *Id.* at 297-98.

278. *Id.* at 292.

279. *Id.* at 300.

280. *Id.* at 301.

281. *Ashingdane v. United Kingdom*, 93 Eur. Ct. H.R. (ser. A) at 20 (1985).

282. See *supra* notes 276-280 and accompanying text (discussing *Bournewood*, in which an adult with severe learning disabilities was informally admitted to a hospital).

283. See *Ashingdane*, 93 Eur. Ct. H.R. (ser. A) at 20 (finding that the petitioner was subject to a restriction order and thus restrained in law).

284. See Mental Health Act 1983, c. 20, §§ 5(2), 5(4) (Eng.).

close attention to the factual and legal realities facing an individual. A failure to exercise a theoretical right to leave an institution should not be dispositive if the person lacks maturity, understanding of her situation, or competence.²⁸⁵ A determination of a “detention” under the ECHR should depend on all the circumstances of the case including the use of force or deception, the person’s resistance to, or displeasure with, restraint and treatment, the person’s mental capacity, and the place, conditions, and duration of confinement.²⁸⁶ In *Bournewood*, the hospital prevented the patient’s caregivers from visiting him.²⁸⁷ Philip Fennell suggests that this “aggravating factor” might convince the European Court of Human Rights that there had been a deprivation.²⁸⁸

b. The Problem of Compulsory Supervision in the Community.—Compulsory supervision of persons with mental disabilities in the community has stimulated considerable interest in mental health policy circles. Pressure for community supervision arises from growing public perceptions that de-institutionalization failed and that greater numbers of mentally disabled persons in the community pose a public risk.²⁸⁹ Various national schemes may require persons with mental disabilities to live in specified residences, to attend specified places for purposes of counseling, education, or training, to permit access by mental health professionals to their homes, or to submit to compul-

285. See *Guenat v. Switzerland*, App. No. 24772/94, 81-B Eur. Comm’n H.R. Dec. & Rep. 130, 131 (1995) (failing to consider the effect that the detainee’s medicine had on his mental capacity).

286. See *Amuur v. France*, 1996-III Eur. Ct. H.R. 826, 850-51 (noting that the court must assess a number of criteria to determine if an appellant has been detained); see also Mental Health Act 1983 Revised Code of Practice, HSC 1999/O5O at § 18.27, available at <http://www.doh.gov.uk/pub/docs/doh/mhcop.pdf> (recommending that an incompetent person should be detained only if she “persistently and/or purposely” tries to leave the hospital).

287. *R. v. Bournewood*, 3 All E.R. 289, 292 (H.L. 1998).

288. Philip Fennell, *Doctor Knows Best? Therapeutic Detention Under Common Law, the Mental Health Act, and the European Convention*, 6 MED. L. REV. 322, 325 (1998).

289. See Allen & Smith, *supra* note 46, at 343-45 (arguing that outpatient commitment programs are not effective and are of questionable legal validity); Paul S. Appelbaum, *Thinking Carefully about Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 347, 348-50 (2001) (reviewing questions that policy makers should address in considering outpatient commitment statutes); Jeffrey W. Swanson et al., *Involuntary Out-patient Commitment and Reduction of Violent Behaviour in Persons with Severe Mental Illness*, 176 BRIT. J. PSYCHIATRY 324, 327-28 (2000) (declaring that involuntary out-patient commitment has a significant effect on reducing violent behavior in people who have severe mental illness); J.C. Phelan & B.G. Link, *The Growing Belief That People with Mental Illnesses Are Violent: The Role of the Dangerousness Criterion for Civil Commitment*, 33 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY S7 (1998) (studying the effect of the dangerousness criterion for involuntary admission on the public’s perception of mentally ill persons as violent).

sory psychiatric treatment.²⁹⁰ These powers adversely affect several important aspects of human dignity, including autonomy, association, and privacy.

The European Court's jurisprudence is still insufficiently developed to predict whether, in the more extreme cases, community control would amount to a detention. There is certainly a "detention" when a hospital actually admits, or re-admits, patients in the community.²⁹¹ At that moment, the full panoply of human rights under Article 5 takes effect.²⁹² However, only the most intrusive forms of restraint in the community are likely to be of sufficient intensity and degree to constitute a deprivation of liberty. The European Commission, for example, has found that provisional discharge conditioned on the patient accepting medical treatment on an outpatient basis was not a "deprivation of liberty."²⁹³ Because of the serious effects on human rights, the regional human rights systems should develop effective methods to ensure that governments justify the most intrusive forms of community supervision.²⁹⁴

2. *Justification for Detention Based on Mental Disability in the European System.*—Article 5(1) of the ECHR lists the only circumstances in

290. Community treatment orders are used in the United Kingdom, United States, Canada, and elsewhere. See Mental Health (Patients in the Community) Act 1995, c. 52, § 4 (Eng.), available at http://www.hms.gov.uk/acts/acts1995/UKpga_19950052_en_2.htm (providing that a patient's responsible medical officer may make an application for a community care order which would improve conditions to ensure that the patient receives medical treatment and after-care services); Mental Health Act, R.S.O., ch. M.7, § 33.1(3)(1990) (Ont.), available at http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90m07_e.htm (providing for community treatment orders for certain individuals with serious mental disorders); John Dawson et al., *Ambivalence about Community Treatment Orders*, 26 INT'L J.L. & PSYCHIATRY 243, 243 (2003) (describing the growing use of community treatment orders around the world).

291. See *Ashingdane v. United Kingdom*, 93 Eur. Ct. H.R. (ser. A) at 8-9, 18 (1985) (submitting that both petitioner and the state thought the hospital was detaining the petitioner when it admitted him because of mental illness).

292. ECHR, *supra* note 35, art. 5(1) ("No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.").

293. *L. v. Sweden*, App. No. 10801/84, 61 Eur. Comm'n H.R. Dec. & Rep. 62, 73 (1988).

294. As suggested above, the European Court itself has said that restrictions of movement should be considered under Article 2 of Protocol No. 4: "Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement . . ." Protocol No. 4, *supra* note 266, art. 2; see *Amuur v. France*, 1996-III Eur. Ct. H.R. 826, 848 ("[m]ere restrictions upon liberty of movement . . . are governed by Article 2 of Protocol No. 4"). Community powers might also implicate, for example, Article 8 (respect for private and family life), Article 11 (freedom of association), or Article 13 (an effective remedy for violation of ECHR rights). See ECHR, *supra* note 35, arts. 8, 11, 13. Oliver Thorold, however, concludes that "[c]ommunity controls . . . appear to be treated as insufficiently invasive or serious to engage any of the relevant Articles of the Convention." See Thorold, *supra* note 206, at 632.

which governments may justifiably deprive a person of liberty.²⁹⁵ Subparagraph (e) addresses one such instance: “the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.”²⁹⁶ The ECHR, therefore, groups together persons of unsound mind with other individuals marginalized in society and subject to confinement without a criminal conviction. The state interest in prevention of infectious disease is certainly legitimate because the ECHR frames it in terms of public protection.²⁹⁷ A similar state interest does not justify the confinement of the remaining categories of individuals subject to detention under this provision. Rather, they are persons characterized by a series of personal statuses based on health or socio-economic status.²⁹⁸ The fact that an individual is in poor health from mental illness, dependent on alcohol or drugs, or has no visible means of support does not, in itself, warrant detention. Additional findings of dangerousness and that the person will benefit from treatment are necessary to justify detaining people who belong to these groups.²⁹⁹

Despite the ECHR’s failure to state clearly and precisely a rigorous justification for detention on grounds of mental disability, the European Court has imposed reasonably strong standards under Article 5(1)(e). First, the detention must be “lawful,” meaning that the government must follow a “procedure prescribed by law” and cannot act arbitrarily.³⁰⁰ Second, the person must be of “unsound mind.”³⁰¹

295. ECHR, *supra* note 35, art. 5(1).

296. *Id.* art. 5(1)(e). It should also be noted that, in addition to Article 5(1)(e) of the ECHR, governments can detain mentally disordered offenders admitted to a hospital using either Article 5(1)(a) (“lawful detention of a person after conviction by a competent court”) or Article 5(1)(b) (“lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfillment of any obligation prescribed by law”). *Id.* art. 5(1)(a)-(b). See *Nowicka v. Poland*, App. No. 30218/96, para. 60 (Dec. 3, 2002) (Court report), at <http://hudoc.echr.coe.int> (authorizing detention of the patient pursuant to Article 5(1)(b)).

297. See ECHR, *supra* note 35, art. 5(1)(e) (stating that the purpose of the detention is to prevent the spread of infectious disease).

298. See *id.* (authorizing “the lawful detention of . . . alcoholics or drug addicts or vagrants”).

299. The European Court has attempted to justify the detention of these vulnerable groups based upon protection from themselves and from the public. “The reason why the Convention allows [persons of unsound mind, alcoholics, and drug addicts] to be deprived of their liberty is not only that they have to be considered as occasionally dangerous for public safety but also that their own interests may necessitate their detention.” *Guzzardi v. Italy*, 3 Eur. H.R. Rep. 333, 366 (1980) (Court report).

300. ECHR, *supra* note 35, art. 5(1); *Steel v. United Kingdom*, 1998-VII Eur. Ct. H.R. 2719, 2735.

301. ECHR, *supra* note 35, art. 5(1)(e).

Third, she must currently be suffering from a mental illness that warrants confinement for care and treatment.³⁰²

a. “*Lawful Detention*”: *Duty to Conform with Domestic Law and Avoid Arbitrary Decisions*.—Article 5(1)’s phrase “in accordance with a procedure prescribed by law” essentially refers back to domestic law; it states the requirement that the detention must comply with the relevant substantive and procedural rules under that law.³⁰³

The European Court has stated more generally that “lawful” detention must also be consistent with the purposes for which a mental health facility is confining a person.³⁰⁴ Put another way, the government must demonstrate a reasonable relationship between the objectives (to provide care and treatment in the person’s best interests) and the means used to achieve those objectives (reasonable procedures, criteria, and conditions of confinement).³⁰⁵ Governmental action is not reasonable if it is aimless: “[a]ny measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary.”³⁰⁶

The European Court asserts the power to examine whether a national authority has complied with the terms of its own legislation or has otherwise acted arbitrarily, but the scope of review is limited. For example, in *Van der Leer v. The Netherlands*,³⁰⁷ the European Court found a violation of Article 5(1) based on the arbitrary nature of the

302. *Winterwerp v. The Netherlands*, 33 Eur. Ct. H.R. (ser. A) at 18 (1979).

303. *Steel*, 1998-VII Eur. Ct. H.R. at 2735 (noting that “given the importance of personal liberty, it is essential that the applicable national law meet the standard of ‘lawfulness’ set by the Convention, which requires that all law, whether written or unwritten, be sufficiently precise to allow the citizen . . . to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action may entail”); see *Hutchison Reid v. United Kingdom*, App. No. 50272/99, at 13 (Feb. 20, 2003) (Court report), at <http://hudoc.echr.coe.int> (holding that continued detention of the patient was not arbitrary although “the grounds on which detention . . . [could] be ordered in domestic law [had] altered over the period during which the applicant [had] been detained”). An interesting human rights question was presented, but never resolved, in the *Bournewood* case where the House of Lords in the United Kingdom held that the common law doctrine of necessity, rather than mental health legislation, justified a patient’s detention. *R v. Bournewood Community and Mental Health NHS Trust, ex parte L*, 3 All E.R. 289, 298 (H.L. 1998). Arguably, this is a violation of Article 5 (1) because mental health authorities did not follow “a procedure prescribed by law.” ECHR, *supra* note 35, art. 5(1). By relying solely on the common law, they circumvented all the substantive and procedural safeguards intended under mental health legislation. *Bournewood*, 3 All E.R. at 295 (noting that informal patients are admitted “without the formalities and procedures for admission necessary for detention under the [Mental Health] Act”).

304. See *Aerts v. Belgium*, 1998-V Eur. Ct. H.R. 1939, 1962.

305. See *id.*

306. *Winterwerp*, 33 Eur. Ct. H.R. (ser. A) at 20.

307. App. No. 11509/85, 12 Eur. H.R. Rep. 567 (1990) (Court report).

detention.³⁰⁸ The judge failed to hear from the patient or her representative and did not give any reason why he did not hear from her.³⁰⁹ Similarly, in *D.S.E. v. The Netherlands*,³¹⁰ the European Commission found that the government failed to comply with lawful procedures.³¹¹ A mentally disordered offender's period of confinement in a hospital, due to a procedural oversight, was not formally extended because "there was a period of two months and twenty days . . . during which there existed no court decision as the basis of the applicant's detention."³¹²

"Lawful" detention may also require a minimally therapeutic environment.³¹³ This follows from the relationship between the need for detention and the treatment for mental illness.³¹⁴ Detention for the purposes of care and treatment of mentally ill persons cannot be accomplished in punitive or nontherapeutic environments. The idea that the ECHR may impose an affirmative obligation to provide a minimally therapeutic environment is discussed below.

b. Persons of "Unsound Mind."—The entire foundation of mental health law rests on a reliable diagnosis of mental disability. Absent this status, individuals would not be subject to confinement without conviction of a criminal offense. Human rights norms, therefore, stress the importance of a careful and accurate diagnosis of mental disability.³¹⁵

The ECHR requires a finding of unsoundness of mind to justify confinement in a mental hospital, but does not define the term.³¹⁶ The European Court has said that because of the fluidity of the term's usage, it should not be given a definitive interpretation.³¹⁷ The European Court, however, also has stated that Article 5(1)(e) would not

308. *Id.* at 573.

309. *Id.* at 572-73.

310. App. No. 23807/94 (July 2, 1997) (Commission report), at <http://hudoc.echr.coe.int/Hudoc1doc/herrep/sift/553.txt>.

311. *Id.* para. 40.

312. *Id.* para. 39; see also *Erkalo v. The Netherlands*, App. No. 23807/94, 28 Eur. H.R. Rep. 509, 529 (1998) (Court report) (finding that the State's failure to set a hearing date to review continued detention constituted a violation of Article 5(1)(e)).

313. See *Aerts v. Belgium*, 1998-V Eur. Ct. H.R. 1939, 1962 (noting that the institution in which petitioner was detained was not appropriate because it did not provide regular medical treatment or a therapeutic environment).

314. See *id.*

315. See *MI Principles*, G.A. Res. 119, *supra* note 28, Principle 4, [1991] 45 U.N.Y.B. at 621 (providing guidelines for making a determination of mental illness).

316. ECHR, *supra* note 35, art. 5(1)(e).

317. *Winterwerp v. The Netherlands*, 33 Eur. Ct. H.R. (ser. A) at 16 (1979).

permit the detention of a person simply because “his views or behaviour deviate from the norms prevailing in a particular society.”³¹⁸

The lawful detention of persons of unsound mind under the ECHR, except in emergency cases, requires the observance of three minimal conditions.³¹⁹ First, the state must establish through “*objective medical expertise*” that the individual is of unsound mind.³²⁰ The procedural requirement of objective medical evidence is important because it adds legitimacy to the state’s claim that detention is truly necessary for treatment of a person with a mental illness. The medical evidence, according to the European Commission, may come from a general practitioner rather than a psychiatrist,³²¹ although psychiatrists are more likely to meet the MI Principle of an “internationally accepted

318. *Id.* In the former Soviet Union and China, the incarceration of political and religious dissidents in maximum security psychiatric hospitals without medical justification has been well documented. *E.g.*, Richard J. Bonnie, *Political Abuse of Psychiatry in the Soviet Union and in China: Complexities and Controversies*, 30 J. AM. ACAD. PSYCHIATRY & L. 136, 137 (2002); Robin Munro, *Judicial Psychiatry in China and its Political Abuses*, 14 COLUM. J. ASIAN L. 1, 4 (2000). Using over-inclusive definitions of mental disorders, the governments of the former Soviet Union and China were able to hyper-diagnose nonimputable cases of mental illness. Bonnie, *supra*, at 139 (noting hyperdiagnosis of schizophrenia in the Soviet Union); Munro, *supra*, at 82-86 (noting that dangerousness is defined in China to include certain types of dissidents). Determinants of diagnosis included signs that the patient exhibited a “high level of commitment to a single cause” (political reform) and failed to adapt to societal norms (dissidence). Bonnie, *supra*, at 139. During detainment, medicine was routinely used for punitive purposes. Bonnie, *supra*, at 138 (noting that the Soviet Union induced insulin comas and utilized atropine injections and high doses of anti-psychotic drugs for punitive purposes); Munro, *supra*, at 24 (noting that China induced insulin comas and used electroconvulsive shock therapy as methods of punishment). This “misuse of psychiatry for politically repressive purposes” demonstrates the risks associated with unchecked psychiatric power, and the importance of erecting institutional safeguards in the context of involuntary hospitalization and treatment. Munro, *supra*, at 6.

319. *See, e.g.*, *Winterwerp*, 33 Eur. Ct. H.R. (ser. A) at 18.

In the Court’s opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of “unsound mind.” The very nature of what has to be established before the competent national authority—that is, a true mental disorder—calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder.

Id.

320. *X v. United Kingdom*, 46 Eur. Ct. H.R. (ser. A) at 18 (1981) (emphasis added). *See Winterwerp*, 33 Eur. Ct. H.R. (ser. A) at 18-19 (finding that the petitioner’s actions justified an “emergency” confinement and that objective and reliable medical evidence also supported his detention); *Luberti v. Italy*, 75 Eur. Ct. H.R. (ser. A) at 13 (1984) (finding that the appellant was of unsound mind based on two psychiatric reports).

321. *Schuurs v. The Netherlands*, App. No. 10518/83, 41 Eur. Comm’n H.R. Dec. & Rep. 186, 188-89 (1985).

medical standard[].”³²² The European Court has found deprivation of liberty without first consulting a medical expert to be unlawful.³²³

The second criterion for lawful detention is that the mental illness “must be of a *kind or degree warranting compulsory confinement*.”³²⁴ Since the ECHR does not define unsoundness of mind, persons with relatively minor mental health problems conceivably could be subject to detention. The European Court has made clear, however, that the mental disability must be of sufficient seriousness to justify deprivation of liberty.³²⁵

Furthermore, the phrase “mental disorder . . . of a kind or degree warranting compulsory confinement” does not require that the patient’s condition be treatable.³²⁶ Arguably, a mental hospital should not confine a patient with an untreatable condition, such as a psychopathic disorder. Yet, the European Court has rejected this argument, reasoning that public protection may justify confinement, even if the mental illness is untreatable.³²⁷

The third criterion is that “the validity of *continued confinement depends upon the persistence of such a disorder*.”³²⁸ Accordingly, even if the

322. *MI Principles*, G.A. Res. 119, *supra* note 28, Principle 4, [1991] 45 U.N.Y.B. at 621.

323. See *Varbanov v. Bulgaria*, App. No. 31365/96, para. 48 (Oct. 5, 2000) (Court report), at <http://hudoc.echr.coe.int> (finding that the detention of a patient for 25 days based on an order issued without consulting a medical expert was unlawful because the case did not involve an emergency); *Nowicka v. Poland*, App. No. 30218/96, paras. 64-65 (Dec. 3, 2002) (Court report), at <http://hudoc.echr.coe.int> (holding that two court-ordered detentions totaling 83 days violated Article 5(1) since the detentions were to conduct psychiatric examinations that normally took only a few hours and were based on a private dispute).

324. *Winterwerp*, 33 Eur. Ct. H.R. (ser. A) at 18 (emphasis added).

325. *Varbanov*, App. No. 31365/96, para. 46 (noting that a detention is warranted only if other less restrictive measures would be ineffective).

326. See *Winterwerp*, 33 Eur. Ct. H.R. (ser. A) at 18; see also *Hutchison Reid v. United Kingdom*, App. No. 50272/99, paras. 52-55 (Feb. 20, 2003) (Court report), at <http://hudoc.echr.coe.int> (holding that detention was appropriate although patient suffered from a psychopathic personality disorder because of the finding that he had a high risk of re-offending).

327. See *Hutchison Reid*, App. No. 50272/99, para. 52 (holding that the decision not to release an applicant with an untreatable psychopathic disorder because of the high risk to the community did not violate Article 5(1)(e)). Courts in the United Kingdom have similarly interpreted ECHR case law. See *A v. Scottish Ministers*, 2002 S.L.T. 1331, 1338 (explaining the legitimacy of detaining an individual because of public health concerns); see also *Regina (H) v. London N. & E. Region Mental Health Review Tribunal*, 3 W.L.R. 512, 521 (2001) (holding that the ECHR requires a mental disorder as a precondition for confinement).

328. *Winterwerp*, 33 Eur. Ct. H.R. (ser. A) at 18 (emphasis added); *Ashingdane v. United Kingdom*, 93 Eur. Ct. H.R. (ser. A) at 18 (1985); *X v. United Kingdom*, 46 Eur. Ct. H.R. (ser. A) at 18 (1981); see also Larry Gostin, *Human Rights, Judicial Review and the Mentally Disordered Offender*, 1982 CRIM. L. REV. 779, 782 (listing the three conditions necessary to lawfully confine a person of unsound mind).

person had a sufficiently serious form of mental disability at the time of admission, the hospital must discharge her when she achieves a state of mental health that no longer warrants confinement.³²⁹ Logically, the government must have in place a mechanism for ongoing review of a person's mental status to ensure that all confined individuals continue to have a mental disability sufficient to necessitate confinement.

Notably, the European Court found that, simply because an expert authority determines that the applicant is no longer suffering from mental disorder, the law does not require his immediate and *unconditional* release into the community.³³⁰ Such a rigid approach would constrain the exercise of judgment as to whether "the interests of the patient and the community into which he is to be released would in fact be best served" by an immediate and unconditional discharge.³³¹ The European Court acknowledged that a responsible authority should be able to "retain some measure of supervision over the progress of the person once he is released into the community and to . . . make his discharge subject to conditions."³³² However, safeguards must be in place to assure that the hospital does not unreasonably

329. See X, 46 Eur. Ct. H.R. (ser. A) at 18.

330. *Johnson v. United Kingdom*, App. No. 22520/93, 27 Eur. H.R. Rep. 296, 322-23 (1997) (Court report) (finding that although the applicant no longer suffered from a mental illness, a phased conditional discharge was appropriate).

331. *Id.* at 322.

332. *Id.* at 323. In the United Kingdom, the Court of Appeal in *Regina (K) v. Camden and Islington Health Authority* further considered the applicability of Article 5 to a Tribunal's decision to discharge a patient subject to conditions. 2002 Q.B. 198. The Court of Appeal distinguished between two kinds of cases. *Id.* at 228. The first is a case, like *Johnson*, where the tribunal finds the patient is no longer suffering from a mental disorder, but needs to be discharged into a controlled environment as part of a structured period of rehabilitation. *Id.* In such a case, Article 5(1)(e) requires that the conditions, as well as the period of time needed to comply with the conditions, must be proportionate to the objectives and cannot become indefinite. *Id.* at 229. For example, if the tribunal imposes a condition which proves inordinately difficult and time-consuming to perform, there may be a violation of the Convention. *Id.*

The second is a case, like in *Camden and Islington Health Authority*, where the tribunal concludes that the patient is mentally ill, but could be treated appropriately in the community. *Id.* at 228. Lord Phillips MR said:

If a health authority is unable, despite the exercise of all reasonable endeavours, to procure for a patient the level of care and treatment in the community that a tribunal considers to be a prerequisite to the discharge of the patient from hospital, I do not consider that the continued detention of the patient in hospital will violate the right to liberty conferred by article 5.

Id. at 229. He also explained that:

Whether or not it is necessary to detain a patient in hospital for treatment may well depend upon the level of facilities available for treatment within the community. Neither article 5 nor European Court of Human Rights jurisprudence lays down any criteria as to the extent to which member states must provide facilities

delay discharge.³³³ In *Johnson*, a Mental Health Review Tribunal found that Johnson no longer suffered from a mental illness, but deferred his conditional discharge until arrangements could be made for suitable hostel accommodation.³³⁴ However, the appointed social worker could not find a suitable hostel, and Johnson remained in the hospital for an additional four years.³³⁵ The European Court held that, although a deferral of conditional discharge was justified in principle, Article 5(1)(e) did not permit Johnson's detention because the hospital did not use the necessary safeguards to ensure that it did not unreasonably delay Johnson's release.³³⁶

It is important to note that the three standards for compliance under Article 5(1)(e) (i.e., reliable evidence of mental disorder, the disorder warrants detention in hospital, and continued confinement depends upon the persistence of the disorder) may not apply in emergency situations. The European Court has stated that an emergency case might not require objective medical expertise in advance of detention.³³⁷ If domestic law authorizes emergency admission to a hospital, the ECHR does not always require a thorough medical examination prior to arrest or detention if it is impracticable.³³⁸ In the European Court's view, "[a] wide discretion must in the nature of things be enjoyed by the national authority empowered to order such emergency confinements."³³⁹ Where a risk exists that a patient will pose a public threat or will suffer a serious deterioration of his mental health, the expert evaluation may take place after admission.³⁴⁰ In such circumstances, the public's safety or the patient's best interests may prevail over the individual's right to liberty and may justify emergency confinement without employment of Article 5(1)(e)'s implied safeguards.³⁴¹ Nevertheless, a thorough medical examination must, in all cases, occur promptly after emergency admission.³⁴²

for the care of those of unsound mind in the community, thereby avoiding the necessity for them to be detained for treatment in hospital.

Id. at 228-29.

333. *See Johnson*, 27 Eur. H.R. Rep. at 297.

334. *Id.* at 302-03.

335. *Id.* at 302-06.

336. *Id.* at 314.

337. *See Winterwerp v. The Netherlands*, 33 Eur. Ct. H.R. (ser. A) at 18 (1979).

338. *X v. United Kingdom*, 46 Eur. Ct. H.R. (ser. A) at 19 (1981).

339. *Id.*

340. *See id.* (rejecting the inference that "objective medical expertise" must always be obtained before a hospital confines a person on the grounds of mental disability).

341. *Id.* at 21.

342. *See id.* (explaining that, after a patient's emergency confinement, his further detention must satisfy the minimum conditions in Article 5(1)(e)).

c. *Summary of Article 5(1)(e) of the ECHR.*—In summary, Article 5(1)(e) of the ECHR places the following limitations on involuntary detention of persons on grounds of mental illness. First, government must comply with domestic law by following all democratically imposed criteria and procedures.³⁴³ Second, government must act consistently with the purpose of confinement, which is to provide care and treatment in the person's best interests.³⁴⁴ This means that authorities may not act arbitrarily and that the circumstances and conditions of confinement must be compatible with treatment rather than punishment.³⁴⁵ Finally, the person must be suffering from a mental illness sufficient to justify confinement and must continue to suffer from such a mental illness.³⁴⁶ Government, moreover, must produce independent evidence that reliably diagnoses the person as mentally ill within internationally accepted medical standards.³⁴⁷ Government may not detain persons for an unreasonable period when they are subject to conditional release into the community.³⁴⁸

3. *The Right to a Review of Detention by a Court in the European System.*—Article 5(4) of the ECHR states that "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."³⁴⁹ Article 5(4) affords an individual fundamental rights to: (1) a review of the lawfulness of her detention, (2) by a court, (3) in a reasonably prompt manner, and (4) with the power to release her if she is being unlawfully detained.³⁵⁰

a. *Review of the "Lawfulness of Detention."*—Persons who have been deprived of their liberty on grounds of mental disability must have the right "to take proceedings at reasonable intervals before a court to put in issue the 'lawfulness' of his detention, whether that detention was ordered by a civil or criminal court or by some other

343. *Id.* at 19.

344. *See* Aerts v. Belgium, 1998-V Eur. Ct. H.R. 1939, 1961-62 (noting that the primary goal of Article 5 is to protect the patient).

345. *Id.*

346. X, 46 Eur. Ct. H.R. (ser. A) at 18.

347. *See id.* at 19 (explaining that a deprivation of liberty that is in accordance with domestic law may not be lawful under Article 5(1)(e) if the patient is not "shown to be of unsound mind by objective medical evidence").

348. Johnson v. United Kingdom, App. No. 22520/93, 27 Eur. H.R. Rep. 296, 314 (1997) (Court report).

349. ECHR, *supra* note 35, art. 5(4).

350. *See id.*

authority.”³⁵¹ The European Court has expansively construed the phrase “proceedings by which the lawfulness of his detention shall be decided.”³⁵² The independent review of detention must achieve two clear purposes.³⁵³ First, the review must examine whether authorities have acted in accordance with the applicable procedures and criteria set forth under domestic law.³⁵⁴ Second, the review must examine whether authorities have complied fully with the ECHR.³⁵⁵ The authorities must have followed all of the standards in Article 5(1)(e) including the proscription against arbitrary detention and the requirement of independent medical evidence demonstrating that the person is, and continues to be, of unsound mind.³⁵⁶ The European Court, therefore, has insisted that the independent review of detention must not be a mere formality, but must provide a serious examination of the merits of the case.³⁵⁷ While the review body need not substitute its decision for that of the decision-making authority, it must nevertheless assure that the person is, in fact, mentally disabled to the extent necessary to justify involuntary confinement.³⁵⁸

b. Review by a “Court.”—The ECHR requires that the review of detention be conducted by a “court.”³⁵⁹ The word “court” in Article 5(4) does not signify a court of law of the classic kind, integrated within the judicial machinery of the country. Rather, it requires a body with a judicial character and which affords procedural guarantees to the parties.³⁶⁰ The most important characteristic of a court is

351. X, 46 Eur. Ct. H.R. (ser. A) at 23; *see also* De Wilde v. Belgium, 1 Eur. H.R. Rep. 373, 407 (1970) (Court report) (“Where the decision depriving a person of his liberty is one taken by an administrative body, there is no doubt that Article 5(4) obliges the Contracting States to make available to the person detained a right of recourse to a court.”).

352. ECHR, *supra* note 35, art. 5(4); *see* X, 46 Eur. Ct. H.R. at 25 (“The review should, however, be wide enough to bear on those conditions which, according to the Convention, are essential for the ‘lawful’ detention of a person on the ground of unsoundness of mind, especially as the reasons capable of initially justifying such a detention may cease to exist.”).

353. Under United Kingdom law, courts can review the first purpose (conformity with domestic law) by means of judicial review and habeas corpus while a Mental Health Review Tribunal can review the second purpose (the merits of the case). *See* X, 46 Eur. Ct. H.R. at 25 (explaining that domestic law procedures to determine “lawfulness,” such as that used by the United Kingdom, may not be adequate to decide lawfulness under the ECHR).

354. *Id.* at 24-25 (finding that the government adhered to the United Kingdom’s habeas corpus procedures).

355. *Id.* at 25.

356. *Id.*

357. *See id.* (noting that the scope of judicial review must be sufficient to enable the court to determine whether the illness that initially justified the detention persists).

358. *Id.*

359. ECHR, *supra* note 35, art. 5(4).

360. X, 46 Eur. Ct. H.R. (ser. A) at 23.

independence from the executive and the parties to the case.³⁶¹ This is a critically important safeguard since it assures that the review body does not have a conflict of interest. Since the detaining authority technically rests within the executive branch of government, the European Court insists that the court reside within a different branch.³⁶² Thus, the review body could reside within the judicial branch as a formal court of law or be independent of the executive and judicial branches.³⁶³

A “court” must also follow a procedure of a judicial character, giving the individual fundamental guarantees of natural justice.³⁶⁴ The guarantees required under Article 6 of the ECHR do not have to be present in Article 5(4) judicial proceedings.³⁶⁵ However, the person must have the opportunity to present her own case, either in person or through a representative, and to challenge the medical and social evidence adduced in support of the detention.³⁶⁶ In addition, the government bears the burden of proving that the person meets the criteria for detention.³⁶⁷

Mental disability may entail restricting or modifying the manner of exercise of natural justice, but it cannot justify impairing the very essence of the right. Indeed, it may be necessary to institute special procedural safeguards to protect the interests of mentally disabled persons who are not fully capable of acting independently.³⁶⁸ The fact that an individual’s personal liberty is at stake combined with the nature of the person’s diminished mental capacity requires the gov-

361. *Varbanov v. Bulgaria*, App. No. 31365/96, para. 58 (2000) (Court report), at <http://hudoc.echr.coe.int>.

362. *See id.* para. 60 (invalidating a procedure where a prosecutor’s order was appealable only to other higher-ranking prosecutors).

363. *See X*, 46 Eur. Ct. H.R. at 26 (referring to both judicial and administrative review procedures as appropriate independent review procedures, and explaining that a specialized tribunal may act as a court for purposes of 5(4)(1) provided that it “enjoys the necessary independence”). *But see Thorold*, *supra* note 206, at 625 (arguing that since patients have the burden of proof, Mental Health Review Tribunals do not have to find patients to be suffering from mental disability to justify detention); *id.* at 629 (reasoning that the criteria for discharge by Mental Health Review Tribunals may, in the future, be subject to examination under Article 5).

364. *De Wilde v. Belgium*, 1 Eur. H.R. Rep. 373, 407 (1970) (Court report).

365. Article 6 of the ECHR guarantees a right to fair trial. ECHR, *supra* note 35. *See* discussion of Article 6 *infra* notes 522-537 and accompanying text.

366. *Winterwerp v. The Netherlands*, 33 Eur. Ct. H.R. (ser. A) at 23 (1979); *see also Kawka v. Poland*, App. No. 25874/94, paras. 60-61 (Jan. 9, 2001) (Court report), at <http://hudoc.echr.coe.int> (finding a violation of Article 5(4) because the applicant did not have an opportunity to contest the arguments supporting his detention).

367. *Hutchison Reid v. United Kingdom*, App. No. 50272/99, para. 70 (Feb. 20, 2003) (Court report), at <http://hudoc.echr.coe.int>.

368. *Winterwerp*, 33 Eur. Ct. H.R. (ser. A) at 24.

ernment to provide legal representation.³⁶⁹ The United Kingdom, for example, instituted public financing of MHRT representation in response to a case brought by MIND (the National Association of Mental Health) in the early 1980s.³⁷⁰

c. Review in a "Speedy" Manner.—Article 5(4), in guaranteeing a right to institute proceedings, also affords a right to a "speedy" determination to terminate detention if it proves to be unlawful.³⁷¹ The relevant time period for calculating a delay in judicial review runs from when the patient filed an application for release.³⁷² The European Court has found that delays of four³⁷³ or five³⁷⁴ months violated the ECHR. The European Court, however, went considerably further in *E v. Norway*,³⁷⁵ holding that a delay of eight weeks violated the mandate for a speedy review.³⁷⁶ The European Court has acknowledged that the government may, in exceptional cases, assert a sufficient justification for delays.³⁷⁷ However, primary responsibility for delay rests on the government. Moreover, the complexity of a medical case does not absolve national authorities from their fundamental obligation to afford a prompt review of detention.³⁷⁸ Although isolated delays in

369. *Megyeri v. Germany*, App. No. 13770/88, 15 Eur. H.R. Rep. 584, 593 (1992).

370. Gostin, *supra* note 46, at 361 (discussing the case of *Collins v. United Kingdom* and the resulting changes made to the Mental Health Review Tribunal Rules of Procedure and a regulatory amendment that provided public financing for legal representation).

371. ECHR, *supra* note 35, art. 5(4).

372. *Van der Leer v. The Netherlands*, App. No. 11509/85, 2 Eur. H.R. Rep. 567, 575 (1990) (Court report).

373. *Koendjiharie v. The Netherlands*, App. No. 11497/85, 13 Eur. H.R. Rep. 820, 827 (1990) (Court report).

374. *Van der Leer*, 12 Eur. H.R. Rep. at 575.

375. 181 Eur. Ct. H.R. (ser. A) at 6 (1990).

376. *Id.* at 27; *see also* *Rutten v. The Netherlands*, App. No. 32605/96, para. 54 (2001) (Court report), at <http://hudoc.echr.coe.int> (finding a violation where the first instance court took two months and seventeen days to issue its decision and the appellate court took a further three months to reach its judgment).

377. *See E*, 181 Eur. Ct. H.R. (ser. A) at 27-28 (noting that the court should consider the circumstances of the case to decide whether it was dealt with speedily).

378. *Musial v. Poland*, App. No. 24557/94, 31 Eur. H.R. Rep. 720, 733 (1999) (Court report). Courts in the United Kingdom have followed the European Court's jurisprudence in this area. For example, in *Queen (on the application of C) v. Mental Health Review Tribunal*, No. C/01/0022, 2001 WL 676817 (C.A. July 3, 2001), the Court of Appeal held that the denial of a request for an early hearing date by a solicitor experienced in mental health matters was incompatible with the Convention. *See id.* paras. 58, 66; *see also* *Mental Health Review Tribunals: Time Limits and the ECHR*, 10 MED. L. REV. 89, 90 (2002) (observing that the Court of Appeal considered the practice of routinely listing hearings eight weeks after an application to be arbitrary and unlawful and that the authorities made no attempt to ensure that individual applications were heard as soon as reasonably practicable). The High Court in *R (on the application of KB, MK, JR, GM, LB, PD, and TB) v. Mental Health Review Tribunal*, 2002 WL 498854 (Q.B. Admin. Ct. Apr. 23, 2002), similarly held that pa-

holding hearings do not necessarily violate ECHR rights, systematic delays do. In the words of the European Court: "[T]he Convention places a duty on the Contracting States to organise their legal systems so as to allow the courts to comply with the requirements of [a speedy hearing]."³⁷⁹ Delays in detention reviews not only extend the duration of the detention, they may also lead to the use of inaccurate psychiatric evaluations that no longer depict the current mental state of the person.³⁸⁰

d. The Power to Release Unlawfully Detained Patients.—Article 5(4) provides that a court must have the power to order the patient's release if the detention is not lawful.³⁸¹ Consequently, the court must be vested with the ultimate power to discharge the patient, and may not act merely as an advisory body.³⁸²

e. Incorporated and Periodic Review: Mentally Disordered Offenders.—Hospitals detain mentally disordered offenders not only on the basis of Article 5(1)(e), but also under Article 5(1)(a), which allows "the lawful detention of a person after conviction by a competent court."³⁸³ Presumably, the justification for detention under sub-paragraph (a) ceases once the person has been confined for a period of time that is proportional to the gravity of the offense.³⁸⁴

tients detained under section 3 of the Mental Health Act 1983 were entitled to a Tribunal hearing within eight weeks of the date of their application. *See id.* para. 37. Where, in the absence of any reasoned justification, a hearing did not take place within that timeframe the court found there would be a breach of the Mental Health Act 1983. *Id.* para. 47. This case is particularly interesting because the High Court took into account the resource limitations and administrative problems in the Tribunal system, particularly the large workload and the shortage of medical members. *Id.* paras. 87-92, 112-13. By holding that lack of resources provides an insufficient justification for Tribunal delays, the Court implicitly required additional government expenditures to assure competent and speedy hearings for persons detained under the Act. *See id.* para. 113.

379. *Zimmermann v. Switzerland*, App. No. 8737/79, 6 Eur. H.R. Rep. 17, 24 (1983) (Court report).

380. *See Magalhães Pereira v. Portugal*, App. No. 44872/98, para. 49 (2002) (Court report), at <http://hudoc.echr.coe.int> (finding that the use of a 20-month old psychiatric evaluation to determine whether an individual's detention should continue violated Article 5(4)).

381. ECHR, *supra* note 35.

382. *X v. United Kingdom*, 46 Eur. Ct. H.R. (ser. A) at 26 (1981); *see also Curley v. United Kingdom*, App. No. 32340/96, 31 Eur. H.R. Rep. 401, 408 (2000) (Court report) (finding that because the UK Parole Board did not have the power to order the release of the prisoner the review done by the Parole Board violated Article 5(4)).

383. ECHR, *supra* note 35, art. 5(1)(a).

384. *See X*, 46 Eur. Ct. H.R. (ser. A) at 18 ("The particular circumstances of this case, and notably the fact that X was conditionally released and enjoyed a lengthy period of liberty before being re-detained, may give rise to some doubts as to . . . the continued

Mentally disordered offenders are admitted to a hospital by order of a court, while other patients are admitted under civil powers. Provided the court finds, on the facts, that the person has a mental disability warranting hospital admission, the Article 5(4) judicial review requirement will be deemed satisfied.³⁸⁵ The European Court has repeatedly found that where a court initially orders detention, the judicial review required by the ECHR is incorporated in that decision.³⁸⁶

The initial court order, however, may last only for a period of time that is proportional to the gravity of the offense.³⁸⁷ For example, in *Silva Rocha v. Portugal*, the European Court held that the state could detain a person found not guilty by reason of insanity under sub-paragraph (a) for three years given the seriousness of the offense and the risk to the public; for reviews during that time, the sentencing court incorporated the review required by Article 5(4) into its decision.³⁸⁸ However, once this “tariff” of three years expired, the applicant had the right to further judicial review.³⁸⁹

In the case of confinement of mentally disabled persons, the European Court requires a periodic review of the lawfulness of detention.³⁹⁰ Since mental illness is subject to amelioration and cure, subsequent reviews at reasonable intervals are necessary to ensure that the person’s mental state continues to require detention in a mental hospital.³⁹¹ Moreover, the review body must have the auth-

applicability of sub-paragraph (a)”). Authorities, however, cannot rely on sub-paragraph (a) alone to justify detention in a mental hospital; the Court retains the power to verify, at all times, that the person is of unsound mind under sub-paragraph (e). For a discussion of *X v. United Kingdom*, see *infra* notes 393-411 and accompanying text.

385. See *De Wilde v. Belgium*, 1 Eur. H.R. Rep. 373, 407 (1970) (Court report) (stating that when a court makes the detention decision, Article 5(4) is not offended).

386. *Id.*; *Luberti v. Italy*, 75 Eur. Ct. H.R. (ser. A) at 15 (1984).

387. *Silva Rocha v. Portugal*, 1996-V Eur. Ct. H.R. 1913, 1921.

388. *Id.* at 1921-22.

389. *Id.* at 1922.

390. *X v. United Kingdom*, 46 Eur. Ct. H.R. (ser. A) at 23 (1981).

391. *Luberti*, 75 Eur. Ct. H.R. (ser. A) at 15; *Winterwerp v. The Netherlands*, 33 Eur. Ct. H.R. (ser. A) at 23 (1979). The Court has also required periodic review in certain circumstances “after conviction by a competent court” under Article 5(1)(a). *Thynne v. United Kingdom*, 190 Eur. Ct. H.R. (ser. A) at 27 (1990) (internal quotation marks omitted); see also *Weeks v. United Kingdom*, App. No. 9787/82, 10 Eur. H.R. Rep. 293, 314-15 (1987) (Court report) (holding that applicant was entitled to periodic review when the grounds for his detention were subject to change based on his indeterminate life sentence); *Hutchinson Reid v. United Kingdom*, App. No. 50272/99, para. 65 (2003) (Court report), at <http://hudoc.echr.coe.int> (“An entitlement to a review arises both at the time of the initial deprivation of liberty and where new issues of lawfulness are capable of arising, periodically thereafter.”).

ority to order a release if it finds continued detention unwarranted.³⁹²

f. X v. United Kingdom: A Landmark in Mental Health Law Reform.—*X v. United Kingdom*,³⁹³ one of several test cases brought by MIND³⁹⁴ in the mid-1970s, is one of the most pivotal mental health decisions made by the European Court of Human Rights.³⁹⁵ The case involved section 66 of the United Kingdom's Mental Health Act 1959, which gave the Secretary of State for the Home Department (the Home Secretary) the exclusive authority to discharge patients detained under a hospital order with restrictions on discharge.³⁹⁶ A restricted patient was conditionally discharged from Broadmoor Hospital (a maximum security psychiatric hospital), but the Home Secretary subsequently recalled the patient to that hospital after the patient's wife told a police officer her concerns about her husband's mental state.³⁹⁷ The applicant had at all times complied with the conditions of discharge; there was no medical recommendation sought and no investigation of the facts giving rise to the recall.³⁹⁸ The European Court held that section 66 of the 1959 Act violated Article 5 of the ECHR in several respects.³⁹⁹

First, because mental illness is subject to amelioration and cure, any person detained on grounds of "unsoundness of mind" under Article 5(1)(e) must have a right to *periodic judicial review*.⁴⁰⁰ As explained above, this review must examine not merely whether the detention is in conformity with the domestic law, but whether it is justified on its merits.⁴⁰¹ The applicant did have a habeas corpus fo-

392. *Benjamin v. United Kingdom*, App. No. 28212/95, 36 Eur. H.R. Rep. 1, 9 (2002) (Court report).

393. 46 Eur. Ct. H.R. (ser. A) at 4 (1981).

394. MIND, also known as the National Association for Mental Health, is an advocacy group based in the United Kingdom that supports human rights for persons with mental disability. *About Mind*, at <http://www.mind.org.uk/About+Mind/> (last visited Nov. 10, 2003). One of the authors (Gostin) served as the Legal Director of MIND during the late 1970s. MIND brought several successful and historic cases in front of the European Commission and Court of Human Rights and was instrumental in efforts to reform mental health law in the United Kingdom and throughout Europe.

395. See Nigel Walker, Note, *X v. United Kingdom*, 22 BRIT. J. CRIMINOLOGY 315, 317 (1982) (discussing the changes in the powers of the Mental Health Review Tribunals caused by the Court's decision). See generally Gostin, *supra* note 328 (discussing the implications of *X v. United Kingdom*).

396. *X*, 46 Eur. Ct. H.R. (ser. A) at 7-8.

397. *Id.* at 11-12.

398. *Id.* at 12.

399. *Id.* at 25-27.

400. *Id.* at 23.

401. *Id.*

rum in which to challenge the domestic lawfulness of his detention.⁴⁰² In habeas corpus proceedings, the domestic courts only examine the facial lawfulness of the detention.⁴⁰³ However, with this type of judicial review, patients could not demonstrate that the Home Secretary had acted contrary to law, in bad faith, or in an arbitrary manner, because the remedies available to the patient only went to the legal validity of the detention, not to its merits.⁴⁰⁴ The European Court, therefore, found that habeas corpus did not provide a form of judicial review sufficiently wide in scope to examine substantively the justification of the detention.⁴⁰⁵

Second, neither of the two bodies charged with the duty to review the merits of the case—the Home Secretary and the Mental Health Review Tribunal (MHRT)—were “courts” with the power to order discharge.⁴⁰⁶ The Home Secretary, who made the ultimate decision, was not a court within the meaning of the term because he was not independent of the executive or the parties to the case and did not act judicially.⁴⁰⁷ Indeed, the Home Secretary was both a party to the case (because he was the detaining authority) and a member of the executive branch.⁴⁰⁸ The MHRT, on the other hand, was a court in the sense that it was independent and acted judicially, but it did not have the power to discharge.⁴⁰⁹ The MHRT under the 1959 Act advised the Home Secretary as to the exercise of his powers.⁴¹⁰ Nevertheless, between 1970 and 1975 the Home Secretary rejected in excess of forty percent of all positive recommendations made by the tribunal.⁴¹¹

4. *The Right to be Informed of the Reasons for Arrest.*—Article 5(2) of the ECHR states that “[e]veryone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.”⁴¹² This provision extends beyond the realm of criminal law, to any detention under mental health

402. *Id.*

403. *Id.*

404. *Id.* at 24.

405. *Id.* at 25-26.

406. *Id.* at 26.

407. *See id.* at 7-8 (discussing both the Home Secretary’s role in detention and deferral of cases to the MHRT).

408. *See id.*

409. *Id.* at 26.

410. *Id.* at 8.

411. LARRY GOSTIN, 2 A HUMAN CONDITION 167-74 (1977). The United Kingdom complied with the European Court’s decision in *X v. United Kingdom* by enacting the Mental Health (Amendment) Act 1982 to give restricted patients the right to a binding MHRT review. Mental Health (Amendment) Act, 1982, c. 51 (Eng.).

412. ECHR, *supra* note 35, art. 5(2).

law.⁴¹³ The circumstances in which the Home Secretary exercised his power to recall a restricted patient in *X v. United Kingdom* led the European Commission to note a potential violation of Article 5(2), because the authorities had not promptly informed the applicant of the reasons for his recall.⁴¹⁴

There is a relationship between Article 5(2) and Article 5(4). Article 5(4) provides a right “to take proceedings by which the lawfulness of [a person’s] detention [can] be decided speedily by a court.”⁴¹⁵ A person subject to detention in a mental hospital could not make effective use of the right to a hearing unless someone promptly and adequately informed her of the reasons for the deprivation of her liberty.⁴¹⁶

B. The Conditions of Confinement

Human rights found in regional systems that apply to persons with mental disabilities focus primarily on liberty and security, e.g., assuring adequate standards and procedures for involuntary admission to a hospital and the opportunity for meaningful periodic review by a court or tribunal. But, human rights do not stop at the hospital door. Rather, they set minimal standards for a therapeutic environment and prevention of neglect and abuse of patients.⁴¹⁷ The European System derives these minimal standards from several sources of human rights law: (1) Article 3 of the ECHR, which prohibits inhuman and degrading treatment; (2) Article 5(1) of the ECHR, which prohibits arbitrary detention; and (3) the European Torture Convention, which provides a mechanism for monitoring the conditions of confinement. In the American System, Article 5 of the American Convention establishes a right to humane treatment⁴¹⁸ that those gov-

413. See *Van der Leer v. The Netherlands*, App. No. 11509/85, 12 Eur. H.R. 567, 574 (1990) (Court report) (noting that Article 5(4) makes no distinction between individuals who are arrested and those who are detained and that both are entitled to know the reasons for the deprivation of their liberty).

414. *X*, 46 Eur. Ct. H.R. (ser. A) at 27-28. The Court did not specifically find a violation of Article 5(2), because it thought the Article 5(2) claim was adequately considered under its discussion of the Article 5(1) violations. *Id.* at 29.

415. ECHR, *supra* note 35, art. 5(4).

416. See *Van der Leer*, 12 Eur. H.R. Rep. at 574. The government introduced a detailed procedure for informing restricted patients of the reasons for their recall. For a detailed description of this procedure, see LARRY GOSTIN, MENTAL HEALTH SERVICES 11.13-11.14, 15.10-15.20 (1986).

417. See Gostin, *supra* note 46, at 353-54 (1987) (noting that although the international approach to mental health cannot guarantee improved human rights standards or related policies, it does heighten the “expectation of humane and dignified treatment and respect for rights”).

418. American Convention, *supra* note 68, 9 I.L.M. at 676-77.

erned by it have similarly invoked to argue for improved conditions of confinement.⁴¹⁹ The African Commission has not yet had occasion to address these issues in its Communications. The part that follows discusses the use of regional human rights standards to protect detained persons from exposure to conditions that may demean them and result in a deterioration of their mental health.

1. *Torture or Inhuman and Degrading Treatment or Punishment.*—Article 3 of the ECHR states that “[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment.”⁴²⁰ Unlike most human rights, “there can be no derogation [from Article 3] even” if it is necessary for the public’s health or safety or national security.⁴²¹ The European Commission⁴²² and Court⁴²³ both have found that torture must involve an unlawful or invidious purpose, a point reiterated in the United Nations Torture Declaration.⁴²⁴ As a result, the torture prohibition is unlikely to apply to mental health cases unless there is some anti-therapeutic or unethical motive such as political oppression.⁴²⁵

Inhuman and degrading treatment, unlike torture, does not require a malevolent intent. The *United Nations Detention Principles* explain that “inhuman and degrading treatment or punishment should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental.”⁴²⁶ Mental health professionals who seclude or restrain patients may violate Article 3 of the ECHR

419. See *Hilao v. Estate of Marcos*, 103 F.3d 789, 794 (9th Cir. 1996) (noting Article 5 as an accepted international standard prohibiting inhuman and degrading treatment).

420. ECHR, *supra* note 35, art. 3.

421. *Ribitsch v. Austria*, App. No. 18896/91, 21 Eur. H.R. Rep. 573, 601 (1995) (Court report).

422. *The Greek Case*, 1969 Y.B. Eur. Conv. on H.R. 186 (Eur. Comm’n on H.R.) (urging the government of Greece to abolish its use of torture).

423. See *Ireland v. United Kingdom*, 25 Eur. Ct. H.R. (ser. A) at 66 (1978) (noting that torture has “a special stigma [attached] to deliberate inhuman treatment causing very serious and cruel suffering”).

424. *Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, G.A. Res. 3452, U.N. GAOR, 30th Sess., 3d Comm., Annex, art. 1, U.N. Doc. A/10408, *reprinted in* [1975] 29 U.N.Y.B. 624, 624, U.N. Sales No. E.77.I.1 (providing a detailed definition of torture with a discussion of the intent requirement).

425. Unfortunately, there is a sad tradition in some parts of the world of using psychiatric detention to subvert political opposition. See generally Bonnie, *supra* note 318 (discussing political abuses in the Soviet Union, the United States, and China, as well as the possibility of ending such abuses through human rights and medical ethics).

426. *Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment*, G.A. Res. 173, U.N. GAOR, 43d Sess., 76th mtg., Annex, Principle 6, n.a., *reprinted in* [1988] 42 U.N.Y.B. 510, 511 n.a. U.N. Sales No. E.93.I.100.

even if their purpose is to provide therapy for the patient or security for the institution.⁴²⁷ Article 3, therefore, applies to patients in mental hospitals who claim their caretakers neglected, abused, or placed them in conditions that are unsanitary or unsafe. Since patients are vulnerable by virtue of their mental state and their dependence on the government to meet their needs, special scrutiny of their conditions of confinement is required:

The position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it was for medical authorities to decide, . . . patients nevertheless remain under the protection of Article 3⁴²⁸

In *Ireland v. United Kingdom*,⁴²⁹ the European Court set the standard for inhuman and degrading treatment: Treatment will be inhuman only if it reaches a level of gravity involving considerable mental or physical suffering, and degrading if the person has undergone humiliation or debasement involving a minimum level of severity.⁴³⁰ Inhuman and degrading treatment “depends on all the circumstances of the case,” including the nature and context of the treatment, the manner and method of its execution, its duration, “its physical or mental effects and, in some cases, the [victim’s] sex, age, and state of health.”⁴³¹

In theory, courts can use Article 3 to scrutinize both the conditions of the patients’ confinement and treatment (including compulsory medical treatment).⁴³² Nevertheless, the European Court’s

427. See, e.g., *McFeeley v. United Kingdom*, App. No. 8317/78, 3 Eur. H.R. Rep. 161, 199 (1980) (Commission report) (noting that a denial of facilities for exercise may violate Article 3).

428. *Herczegfalvy v. Austria*, 244 Eur. Ct. H.R. (ser. A) at 25-26 (1992).

429. 25 Eur. Ct. H.R. (ser. A) at 63 (1978).

430. *Id.* at 65; see *Tomasi v. France*, App. No. 12850/87, 15 Eur. H.R. Rep. 1, 29 (1992) (Court report) (finding a violation of Article 3 when a prisoner sustained blows of such intensity to meet the *Ireland* standard). But see *Kudla v. Poland*, 2000-XI Eur. Ct. H.R. 198, 225 (finding no violation of Article 3 because ill-treatment failed to reach a minimum level of severity).

431. *Ireland*, 25 Eur. Ct. H.R. (ser. A) at 65; see *Tyrer v. United Kingdom*, 26 Eur. Ct. H.R. (ser. A) at 15 (1978) (noting the case-by-case nature of determining whether a punishment is degrading); see also *Costello-Roberts v. United Kingdom*, 247 Eur. Ct. H.R. (ser. A) at 59 (1993) (reiterating that *Tyrer* established such a case-by-case determination for evaluating whether a punishment is degrading).

432. The European Commission has found in one case that unpleasant side effects of psychiatric treatment with medication were not sufficiently serious to constitute inhuman and degrading treatment under Article 3. *Grare v. France*, App. No. 18835/91, 15 Eur. H.R. Rep. Comm’n Supp. 100, 100 (1993). Several countries have also examined this issue

Article 3 jurisprudence has been highly deferential to mental health authorities. The European Court reflected this deference in *Herczegfalvy v. Austria*, finding that while the Court would make the ultimate determination under Article 3, “it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients.”⁴³³ In this case, a psychiatric hospital had admitted the applicant in a weakened state following a hunger strike.⁴³⁴ Against his will, he was force-fed and given strong doses of sedatives.⁴³⁵ As a result of his aggressive behavior, the hospital workers sometimes attached him to a security bed by a net and straps and restrained him with handcuffs and a belt around his ankles.⁴³⁶ Although the European Court found the prolonged use of handcuffs and the security bed disturbing, it determined that the restraint was medically justified.⁴³⁷

The European Court, therefore, has traditionally embraced a medically oriented standard that requires the government to demonstrate that the conditions or treatment at issue fall within internationally recognized mental health standards. The European Commission and Court, in applying this medically based standard, have typically deferred to the judgments of mental health professionals—in one case finding no violation⁴³⁸ even though a mentally disturbed prisoner came to feel that he was being treated like an animal.⁴³⁹ Con-

under their domestic law. In *R (on the application of Wilkinson) v. Responsible Medical Officer*, 1 W.L.R. 419 (Eng. C.A. 2002), the United Kingdom Court of Appeal applied Article 3 of the Convention to section 63 of the Mental Health Act, which permits treatment without consent in certain circumstances. *Id.* para. 83. The European Court of Human Rights has also held that “a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.” *Herczegfalvy*, 244 Eur. Ct. H.R. (ser. A) at 26. The United States Supreme Court has also validated treatment without consent to compel persons to be competent to attend trial if there is concern about the person being dangerous. *Sell v. United States*, 123 S. Ct. 2174, 2187 (2003).

433. *Herczegfalvy*, 244 Eur. Ct. H.R. (ser. A) at 26.

434. *Id.* at 25.

435. *Id.*

436. *Id.* at 26.

437. *Id.*

438. *Hilton v. United Kingdom*, App. No. 5613/72, 3 Eur. H.R. Rep. 104, 128 (1978) (Commission Report).

439. *Id.* at 120 (noting that an inmate in Liverpool prison felt “like an animal to . . . such an extent that he would roll in his own excrement”). *But see Keenan v. United Kingdom*, App. No. 27229/95, 33 Eur. H.R. Rep. 913, 964-65 (2001) (Court report) (finding a violation of Article 3 where a mentally unstable prisoner committed suicide after being placed in segregation for seven days and having his prison sentence extended by twenty-eight days); *see infra* notes 465-470 and accompanying text for further discussion of *Keenan*.

sider the permissive view taken in *B. v. United Kingdom*,⁴⁴⁰ *Dhoest v. Belgium*,⁴⁴¹ and *Aerts v. Belgium*.⁴⁴²

B. v. United Kingdom was another test case brought by MIND in the mid-1970s.⁴⁴³ In that case, a patient at Broadmoor Hospital complained that the State was detaining him in grossly overcrowded conditions, characterized by “inadequate sanitary [(e.g., toilet and washing)] facilities,” and a “constant [atmosphere] of violence.”⁴⁴⁴ He alleged that dormitory beds were only eight to fifteen inches apart, that there was no privacy, and that he received little fresh air or exercise.⁴⁴⁵ The applicant claimed he had received no treatment whatsoever and almost never saw his doctor.⁴⁴⁶ The European Commission determined his complaint to be admissible for the following reasons:

The physical conditions in Broadmoor Hospital are admittedly unsatisfactory and have been criticised by different official bodies over a number of years. Whilst the hospital staff may . . . do their best to cope with these inadequacies, this does not itself exclude the possibility that the physical conditions of detention could in themselves give rise to a question under Art[icle] 3. The [European] Commission considers that the applicant’s different allegations concerning the conditions of his detention and the question of his medical treatment must be looked at together and, if so examined, raise issues under Art[icle] 3 which require investigation and examination on the merits.⁴⁴⁷

The European Commission subsequently ruled against the applicant on the merits because of the absence of a single incident sufficiently grave on its own to warrant a finding of inhuman and degrading treatment.⁴⁴⁸ The European Commission’s decision leaves in doubt whether Article 3 would take cognizance of the totality of conditions in the absence of a single factor so gross as to shock the conscience. The European Commission’s position, however, is not consistent with the European Court’s Article 3 jurisprudence, which stresses that inhuman and degrading treatment depends on *all* the circumstances of

440. App. No. 6870/75, Eur. Comm’n H.R. Rep. (1981).

441. App. No. 10448/83, 55 Eur. Comm’n H.R. Dec. & Rep. 5, 23 (1987).

442. 1998-V Eur. Ct. H.R. 1939.

443. *B.*, App. No. 6870/75, para. 15.

444. *Id.* para. 5.

445. *Id.* para. 132.

446. *Id.* paras. 187, 199.

447. *Id.* Annex II, para. 2.

448. *Id.* paras. 177-181.

the case.⁴⁴⁹ Indeed, many forms of torture and inhuman and degrading treatment do not involve merely one horrific act, but rather a regime that is unconscionably cruel in its totality.

In *Dhoest v. Belgium*, the European Commission found no violation of Article 3 when caretakers tied down a patient to his bed overnight and forcibly administered tranquilizers to him.⁴⁵⁰ The European Commission said that, although a person's revolt or non-cooperation does not excuse inhuman and degrading treatment, "[h]aving regard to all the circumstances . . . and in particular to his hostility towards . . . treatment . . . the . . . conditions of detention did not attain the seriousness of [inhuman and degrading] treatment envisaged by Article 3 of the Convention."⁴⁵¹

In *Aerts v. Belgium*, the European Court again found no violation of Article 3 despite the fact that the psychiatric wing of Lantin Prison was detaining a mentally ill person.⁴⁵² The European Committee for the Prevention of Torture and Inhuman and Degrading Treatment had harshly criticized the detention on the grounds that it did not meet "minimum acceptable . . . ethical and humanitarian" standards.⁴⁵³ Yet, the European Court held that "[t]he living conditions . . . do not seem to have had such serious effects on his mental health as would bring them within the scope of Article 3 . . . [and] it has not been conclusively established that the applicant suffered treatment that could be classified as inhuman or degrading."⁴⁵⁴

In another Article 3 case brought by MIND during the mid-1970s, *A. v. United Kingdom*,⁴⁵⁵ the European Commission secured a friendly settlement that implicitly recognized that certain forms of seclusion, even if ordered by medical authority, can be inhumane.⁴⁵⁶ A patient at Broadmoor Hospital complained under Article 3 that the hospital had subjected him to inhuman and degrading treatment during a period of seclusion that lasted five weeks following his suspected involvement in the arson of one of the hospital wards.⁴⁵⁷ The hospital gave the patient only very limited opportunities for exercise or association, deprived him of adequate furnishings and clothing, and placed him

449. *Dhoest v. Belgium*, App. No. 10448/83, 55 Eur. Comm'n H.R. Dec. & Rep. at 23 (1987).

450. *Id.* at 22-23.

451. *Id.* at 23.

452. *Aerts v. Belgium*, 1998-V Eur. Ct. H.R. 1940, 1966.

453. *Id.*

454. *Id.*

455. App. No. 6840/74, 3 Eur. H.R. Rep. 131 (1980) (Commission report).

456. The friendly settlement was adopted in July 1980. *Id.*

457. *Id.* at 131-32.

in a room that was unsanitary and without adequate light and ventilation.⁴⁵⁸ *A. v. United Kingdom* demonstrates that, although the European Commission and Court have not been highly sympathetic to claims of inhuman and degrading treatment, Article 3 can still be an important source of law to improve the most deplorable conditions in mental hospitals.

The European Court has addressed the issue of whether the ECHR prohibits removal or deportation of a person with mental illness to countries that do not offer adequate care. In *Bensaid v. United Kingdom*,⁴⁵⁹ the European Court upheld a decision by the Home Office in the United Kingdom to remove a person with schizophrenia to his home country of Algeria on grounds that his marriage in England was "one of convenience."⁴⁶⁰ There was no violation of Article 3 even though treatment for his mental illness would be more difficult in Algeria.⁴⁶¹ Article 3, the Court said, includes situations where the source of the treatment complained of is beyond the State's control, but a "high threshold" is needed where the State is not "direct[ly] responsib[le] . . . for the . . . harm."⁴⁶² The patient could obtain treatment in Algeria at a hospital seventy-five kilometers from his home.⁴⁶³ The fact that treatment would be harder for him to obtain in Algeria than in the UK was not conclusive for purposes of Article 3.⁴⁶⁴

458. *Id.* at 132. Further details of the parties' submissions are set out in the decision on admissibility in 10 Dec. & Rep. 5 (Eur. Comm'n H.R. 1978). The friendly settlement included an *ex gratia* payment to the applicant and a requirement that new working guidelines for the seclusion of patients at Broadmoor Hospital be introduced. *A.*, 3 Eur. H.R. Rep. at 132. Rooms used for seclusion must now be at least 4.7 square meters and have natural lighting; an individual program of care must be drawn up; patients must have suitable clothing and footwear, mattresses and bedding, and reading matter. *Id.* at 133-34. Unless a patient's condition precludes it, the hospital must let him out of his room to use the toilet, give him at least 30 minutes exercise each morning and afternoon, and allow him to have visitors. *Id.* at 134. Hospital caretakers will observe patients in seclusion at irregular intervals that do not exceed 15 minutes. *Id.* The caretakers should keep a special record book that tracks the beginning and ending time of seclusion, the grounds for the seclusion, the details of what clothing and bedding the caretakers give the patient, and any observations and reviews that they make. *Id.*

459. 2001-I Eur. Ct. H.R. 305.

460. *Id.* at 311.

461. *Id.* at 321.

462. *Id.* at 306-07.

463. *Id.* at 313.

464. *But see* *D. v. United Kingdom*, 1997-III Eur. Ct. H.R. 778, 793 (finding that it would constitute inhuman and degrading treatment to deport an immigrant with AIDS to his home country where his health would likely deteriorate quickly). The United Kingdom courts have quashed deportation orders by the Secretary of State, finding that, if the removal of an individual to a country with inadequate mental health services would severely affect his health, then the deportation order contravenes Article 3 of the ECHR. *See* *R v. Sec'y of State for the Home Dep't, ex parte Kebbeh*, Case No. CO-1269-98 (Q.B. 1999)

The cases above demonstrate the high threshold set by the European Court for triggering an Article 3 violation. The European Commission and Court have been so deferential in their Article 3 decisions that they have never found that conditions in a mental hospital were sufficiently inhuman and degrading to breach Article 3. In two important cases, however, the European Court recently has revisited its Article 3 jurisprudence and applied protections against inhuman and degrading treatment to persons with disabilities in prison settings.

The first case, *Keenan v. United Kingdom*,⁴⁶⁵ involved the suicide of a mentally ill man confined to a prison segregation cell after he assaulted two prison officers.⁴⁶⁶ The deputy Governor extended the prisoner's sentence by twenty-eight days and placed the prisoner in segregation for seven days.⁴⁶⁷ The court found that a lack of effective monitoring and informed psychiatric input by prison officials demonstrated "significant defects in the medical care provided to a mentally-ill person."⁴⁶⁸ Taking into account the prisoner's vulnerability and the authorities' obligation to protect his health, the court determined that the serious disciplinary punishment "threatened his physical and moral resistance" and adversely affected his personality.⁴⁶⁹ The European Court found these actions violated Article 3 because they "constitute[d] inhuman and degrading treatment."⁴⁷⁰

A few months later, the European Court again applied Article 3 to the treatment of a person with disabilities in a prison setting. In *Price v. United Kingdom*,⁴⁷¹ a court sentenced a woman with significant physical disabilities to jail for seven days for contempt of court.⁴⁷² During this period, the prison officials confined her to a regular cell

(finding that an individual with an amputated leg should not be sent back to Gambia because of the inappropriate health care he would receive there); *see also* R v. Sec'y of State for the Home Dep't, ex parte B, Case No. CO-1818-98 (Q.B. 1999) (determining that the Secretary's decision to send an individual back to Germany was unreasonable). *But see* R v Sec'y of State for the Home Dep't, ex parte Kilic, Case No. CO-2112-99 (Q.B. 1999) (upholding a deportation order because the deportation would not result in serious psychological harm to the person).

465. App. No. 27229/95, 33 Eur. H.R. Rep. 913 (2001) (Court report).

466. *Id.* at 923-24.

467. *Id.*

468. *Id.* at 964. The prisoner had been taking anti-psychotic medication and was a known suicide risk, but medical personnel in the prison did not keep adequate daily records of his condition. *Id.* Furthermore, a prison physician who was not a psychiatrist changed the prisoner's medication. *Id.*

469. *Id.*

470. *Id.*

471. 2001-VII Eur. Ct. H.R. 154.

472. *Id.* at 158.

that did not have appropriate facilities for a person with disabilities.⁴⁷³ Thus, the applicant had no choice but to sleep in her wheelchair.⁴⁷⁴ She was unable to use the toilet facilities or access the light switches and emergency buttons because they were all out of her reach.⁴⁷⁵ She experienced serious medical problems as a result of the conditions of her detention.⁴⁷⁶ The court articulated that in determining whether treatment is degrading it will consider whether the person's intent was to humiliate the person concerned.⁴⁷⁷ The court noted that even if it did not find a humiliating purpose, it would not automatically decide that there was no violation of Article 3.⁴⁷⁸ Here the court did not find that the prison officials meant to embarrass the woman, but it nevertheless held that "detain[ing] a severely disabled person" under these circumstances violated the ECHR's prohibition against degrading treatment.⁴⁷⁹

The European Court's use of Article 3 represents a new approach toward protecting the human rights of persons with disabilities. These recent decisions, however, do not present a clear standard or definitive trend. The facts of the cases play a large role in determining whether the court will find that a facility violated the prohibition against inhuman and degrading treatment.⁴⁸⁰ Therefore, it is difficult to predict whether the regional courts will expand this right in future decisions to apply to individuals with mental disabilities in the hospital setting.

Severe maltreatment, neglect or humiliation of patients, or placement of patients in punitive or unsafe environments should give rise to Article 3 claims. While therapeutic intent is important, the European Court has a responsibility to protect patients from serious forms of maltreatment even if administered ostensibly under the guise of

473. *Id.*

474. *Id.*

475. *Id.*

476. *Id.*

477. *Id.* at 163.

478. *Id.*

479. *Id.* at 165. Judge Greve, in a separate opinion for the European Court, extended this argument even further, stating:

In this the applicant is different from other people to the extent that treating her like others is not only discrimination but brings about a violation of Article 3

It is obvious that restraining any non-disabled person to *the applicant's level of ability to move and assist herself*, for even a limited period of time, would amount to inhuman and degrading treatment—possibly torture.

Id. at 169 (emphasis added).

480. See, e.g., *Costello-Roberts v. United Kingdom*, 247 Eur. Ct. H.R. (ser. A) at 59 (1993) (emphasizing the need to consider the facts of each case in human rights violation cases).

medical expertise. It remains unclear whether the European Court will apply the precedents set in *Keenan* and *Price* to analogous situations affecting persons with mental disabilities; however, the increasing attention given to Article 3 claims under the ECHR suggests that in the future the European Court might return to Article 3 as an important source of ECHR law in matters of mental health.

2. *An Anti-Therapeutic Environment as "Arbitrary" Detention.*—Article 5(1)(e) of the ECHR provides another possible route for finding that the conditions of confinement are so anti-therapeutic that they violate the ECHR. As explained above, the European Court has held that the term "lawfulness" under Article 5(1) requires conformity with the domestic law and with the purposes of deprivation of liberty permitted by Article 5(1).⁴⁸¹ In theory, there must be a reasonable relationship between the reasons for confining the person and the means used to achieve these goals.⁴⁸² Under this theory, since the purposes of detention on the grounds of unsoundness of mind are therapeutic, such detention can take place only in a facility equipped to provide minimally adequate care and treatment.⁴⁸³

Initially, in *Ashingdane* and *Dhoest*, European institutions disclaimed a connection between the actual detention (which was naturally a matter for consideration under Article 5) and the conditions of confinement (which was naturally a matter for consideration under Article 3).⁴⁸⁴ Still, the European Court has hinted that Article 5(1)(e) is relevant for reviewing a patient's conditions of confinement. The first sign of this was in the *Ashingdane* case when the European Court found that detention of a person was "lawful" for the purposes of Article 5(1)(e) only if effected in a hospital, clinic, or other appropriate institution.⁴⁸⁵

The European Court appeared to go further in *Aerts v. Belgium* by suggesting that persons with mental illness must be confined in a minimally therapeutic environment:

[T]here must be some relationship between the ground of permitted deprivation of liberty relied on and the place and

481. See *Aerts v. Belgium*, 1998-V Eur. Ct. H.R. 1939, 1962.

482. *Id.*

483. See *id.* (holding unlawful the detention of an unsound patient in a facility when "the aim of the detention and the conditions in which it took place" lacked the appropriate balance, given that the patient received no medical care and did not have a therapeutic environment).

484. *Ashingdane v. United Kingdom*, 93 Eur. Ct. H.R. (ser. A) at 37-38 (1985); *Dhoest v. Belgium*, App. No. 10448/83, 55 Eur. Comm'n H.R. Dec. & Rep. at 25 (1987).

485. *Ashingdane*, 93 Eur. Ct. H.R. (ser. A) at 21.

conditions of detention. In principle, the “detention” of a person as a mental health patient will only be “lawful” for the purposes of sub-paragraph (e) of paragraph 1 if effected in a hospital, clinic or other appropriate institution.⁴⁸⁶

The European Court did not think that the psychiatric wing of a prison was an appropriate place to detain mentally ill persons because it was not a therapeutic environment and did not provide the patient with the medical attention he needed.⁴⁸⁷ The Court found that the connection “between the aim of the detention and the conditions in which it took place was . . . deficient.”⁴⁸⁸

The European Court’s jurisprudence is still too undeveloped to predict whether it will formulate robust criteria for ensuring that mental health facilities provide minimum standards of treatment, care, and protection from abuse. It is not difficult to form a theory supporting a “right to therapeutic conditions” under Article 5. Minimally adequate care and treatment should be a necessary pre-condition to detention on grounds of unsoundness of mind; otherwise, it would be difficult to justify detention on those grounds alone. Put another way, if the government is depriving a person of her liberty because she needs therapy, then the government should have a duty to provide minimally adequate treatment. Minimally adequate standards of treatment would help assure that a person’s mental health does not deteriorate, but actually improves, during confinement.⁴⁸⁹

3. *Monitoring of Torture and Inhuman or Degrading Treatment or Punishment in the European System.*—The Council of Europe designed the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment to strengthen “the protection of persons deprived of their liberty” by “non-judicial means.”⁴⁹⁰ The Convention does not establish international human rights standards for torture or inhuman and degrading treatment. Rather, it provides a mechanism for monitoring and enforcement

486. *Aerts*, 1998-V Eur. Ct. H.R. (ser. A) at 1962.

487. *Id.*

488. *Id.*

489. The United States Supreme Court, for example, has found that a State cannot detain persons with mental illness who are not dangerous and can exist outside of a hospital either by themselves or with the help of their family or friends. *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975).

490. European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Europ. T.S. No. 126 (entered into force Feb. 1, 1989), *available at* <http://www.umn.edu/humanrts/euro/z34eurotort.html>.

through the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.⁴⁹¹

The European Committee examines the treatment of persons deprived of their liberty by making visits to places, such as prisons and hospitals, where a public authority has deprived persons of their liberty.⁴⁹² The Committee, in cooperation with member states, organizes its own visits, carried out by at least two members with the assistance of experts and interpreters.⁴⁹³ In addition to periodic visits, the Committee can schedule other visits as they become necessary.⁴⁹⁴ Before it can visit facilities, the Committee must inform the government concerned that it intends to visit.⁴⁹⁵ After it notifies the government, it can visit facilities whenever it wants.⁴⁹⁶ The government must provide the Committee with “unlimited access” to the place of detention and all the information necessary for the Committee to successfully complete its task.⁴⁹⁷ This information includes the right to interview detained persons in private and the right to “communicate freely” with any relevant person.⁴⁹⁸

The Government “may make representations to the Committee against a visit.”⁴⁹⁹ This procedure is only allowed in exceptional circumstances, e.g., if there are concerns about national security or public safety.⁵⁰⁰

After each visit, the Committee must draft a report describing its conclusions and send this report to the Government with any recommendations it has for improvement.⁵⁰¹ If the Government does not make efforts to improve the facility, then the Committee, if two-thirds of its members agree, can publicly speak about the issue.⁵⁰²

The Committee’s report is confidential, but it must publish it whenever the Government requests.⁵⁰³ However, the Committee cannot publish any personal information unless it gets “the express consent of the person concerned.”⁵⁰⁴ Subject to these confidentiality

491. *Id.* art. 1.

492. *Id.* art. 2.

493. *Id.* art. 7(2).

494. *Id.* art. 7(1).

495. *Id.* art. 8(1).

496. *Id.*

497. *Id.* art. 8(2).

498. *Id.* art. 8(4).

499. *Id.* art. 9(1).

500. *Id.*

501. *Id.* art. 10(1).

502. *Id.* art. 10(2).

503. *Id.* arts. 11(1)-(2).

504. *Id.* art. 11(3).

requirements, the Committee must submit a public report of its activities annually to the Committee of Ministers.⁵⁰⁵

The European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, in many respects, works outside of the conventional human rights framework. Human rights law, by its nature, is publicly visible and binding on governments. The Convention, however, often operates without public scrutiny, uses the power of moral persuasion, and relies on government cooperation. Still, its systematic monitoring of places of detention helps assure compliance with standards set in Article 3 of the European Convention of Human Rights. Additionally, as in *Aerts v. Belgium*, the European Court can use a finding of fact by the European Committee to help adjudicate a human rights case.⁵⁰⁶

4. *Inhuman and Degrading Treatment in the American System.*—The American Commission has adopted a more direct stance than the European Court in requiring governments to protect persons with mental disabilities from inhuman and degrading treatment. In *Victor Rosario Congo v. Ecuador*,⁵⁰⁷ the American Commission found Ecuador in violation of Article 5 of the American Convention, which guarantees humane treatment.⁵⁰⁸ A person with mental disabilities taken into custody was not cooperating with interrogators.⁵⁰⁹ Two days later, guards struck him on the head.⁵¹⁰ The Rehabilitation Center employees did not give him any medical treatment for the resulting injury, and they left him in the cell for forty days.⁵¹¹ Eventually, authorities took him to a hospital to treat his severe dehydration, but Mr. Congo ended up dying in that hospital.⁵¹² The American Commission acknowledged that special standards apply when analyzing American Convention rights with respect to persons with mental disabilities.⁵¹³ Specifically, the MI Principles should act as guidance

505. *Id.* art. 12.

506. 1998-V Eur. Ct. H.R. 1939, 1954-59.

507. Case 11.427, Inter-Am. C.H.R. 63/99, para. 66 (1999), <http://www.cidh.oas.org/annualrep/98eng/Merits/Ecuador%2011427.htm>.

508. *Id.* The American Commission also found a violation of Article 4(1) of the American Convention, the right to life. See also *Hernandez Lima v. Guatemala*, Case 11.297, Inter-Am. C.H.R. 28/96, paras. 58-61 (Oct. 16, 1996), at <http://www.cidh.oas.org/annualrep/96eng/Guatemala11297.htm> (finding a violation of Articles 4 and 5 where the state did not prevent a detained individual from getting cholera in prison).

509. *Victor Rosario Congo*, Inter-Am. C.H.R. 63/99, paras. 6-7.

510. *Id.* para. 9.

511. *Id.* paras. 10-17.

512. *Id.* paras. 18-20.

513. *Id.* para. 53.

for determining whether the person received humane treatment.⁵¹⁴ The Commission found that keeping a person in isolation itself can constitute inhuman and degrading treatment, but when the person in isolation has a mental disability “this could involve an even more serious violation of the State’s obligation to protect the physical, mental and moral integrity of persons held under its custody.”⁵¹⁵ The Commission cited poor conditions and lack of medical treatment as factors in determining where inhuman and degrading treatment has occurred.⁵¹⁶ The Commission concluded that “a violation of the right to physical integrity is even more serious in the case of a person held in preventive detention, suffering a mental disease, and therefore in the custody of the State in a particularly vulnerable position.”⁵¹⁷

The *Congo* case is important and noteworthy for several reasons. First, it was the first time that the Inter-American Commission addressed the rights of persons with mental disabilities. Second, the case set a strong precedent for the protection of these rights under the American Convention, firmly establishing Article 5 as a powerful tool to help prevent deleterious detention and treatment conditions in mental hospitals and related facilities.⁵¹⁸ The holding of the American Commission presented a compelling connection between the right to humane treatment and the protection of persons with mental disabilities under confinement. Third, the American Commission based its conclusions, in the absence of precedent within its own system, on prior holdings by the European Commission and Court, as well as on the MI Principles.⁵¹⁹ This recognition and acceptance of other related sources of international law augurs well for the future development of the American System. Rights and protections of persons with mental disabilities will develop more rapidly if the American

514. *Id.* para. 54.

515. *Id.* para. 58.

516. *Id.* para. 66. The American Commission cites precedent from the European Commission, for the proposition that “the incarceration of a mentally disabled person under deplorable conditions and without medical treatment may be considered inhuman or degrading treatment.” *Id.*; see also *Ashingdane v. United Kingdom*, 93 Eur. Ct. H.R. (ser. A) at 37-38 (1985) (holding that the lawfulness of a patient’s detention would be questionable if he were “incarcerated in appalling conditions with no consideration being given to his treatment”).

517. *Victor Rosario Congo*, Inter-Am. C.H.R. 63/99, para. 67.

518. See *id.* para. 68 (determining that “the State is responsible for not taking the necessary measures to protect the physical, mental and moral integrity of the victim”).

519. *Id.* paras. 57-68.

Commission continues to build on the jurisprudence of the more established European System.⁵²⁰

C. *Civil Rights*

Human rights norms extend to the exercise of a wide array of civil rights both within and outside of institutions. Simply because a person has a mental disability, or is subject to confinement, does not mean she is incapable of exercising rights of citizenship. The regional human rights instruments contain many provisions that can be helpful in securing civil rights for persons with mental disabilities, including the rights of access to the courts, privacy, marriage, and procreation.⁵²¹

1. *The Right to a Fair and Public Hearing When Determining Someone's Civil Rights.*—Article 6(1) of the ECHR states: "In the determination of his civil rights and obligations . . . , everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law."⁵²² The European Court in *Golder v. United Kingdom* held that Article 6 gives everyone the right to bring any claim regarding her civil rights in front of a judicial review body.⁵²³ The Article, therefore, embodies the right of access to a court. The court, moreover, must follow a procedure that is fundamentally fair, including affording litigants a right to representation so that they can present their case "properly and satisfactorily."⁵²⁴

Article 6 rights may be subject to limitations, but the limitations must be based on a legitimate aim, be proportionate to that aim, and cannot restrict judicial access "to such an extent that the very essence

520. The OAS has also promulgated a distinct torture convention applicable to states in the Inter-American system. Inter-American Convention to Prevent and Punish Torture, O.A.S. Treaty Series No. 67, *adopted* Dec. 9, 1985, *available at* <http://www.oas.org/juridico/english/Treaties/a-51.html> (last visited Oct. 6, 2003). However, this convention does not provide for a separate enforcement mechanism similar to the European convention. *See id.* art. 8 (leaving the state to investigate any alleged acts of torture). Countries are required to inform the American Commission of any actions that they have taken to apply the Convention. *Id.* art. 17.

521. *See, e.g.,* ECHR, *supra* note 35, art. 8(1) (securing to everyone a "right to respect for his private and family life, his home and his correspondence").

522. *Id.* art. 6(1).

523. 1 Eur. H.R. Rep. 524, 536 (1975) (Court report).

524. *Airey v. Ireland*, 2 Eur. H.R. Rep. 305, 315 (1979) (Court report). In the United Kingdom, for example, in *R. (on the application of Wilkinson) v. Broadmoor Hospital*, Hale, L.J. ruled that a mental patient had the right to cross-examine medical witnesses relating to his claim that forcible treatment violated his Convention rights. 1 W.L.R. 419 (Eng. C.A. 2002), paras. 63, 82.

of the right is impaired.”⁵²⁵ In *Winterwerp*, the European Court held that “[w]hile . . . mental illness may render legitimate certain limitations upon the exercise of the ‘right to a court,’ it cannot warrant the total absence of that right as embodied in Article 6(1).”⁵²⁶

Persons with mental disability, therefore, have rights guaranteed under the European Convention to judicial determinations to secure their full entitlement to civil rights.⁵²⁷ The European Court has found violations of Article 6 in a number of cases in which persons with mental disabilities either were refused adequate access to a court or experienced unreasonable delays in having their cases heard. The subject matter of these cases varied greatly and included denial of a detained patient’s right to control property,⁵²⁸ a finding of mental incapacity to acquire rights and undertake obligations,⁵²⁹ placement of a person into guardianship,⁵³⁰ and denial of a mentally ill parent’s right of access to her child.⁵³¹

However, in a remarkable case, the European Commission and Court held that the ECHR did not prevent the United Kingdom from requiring persons to obtain permission of the court before instituting judicial proceedings in securing their rights under mental health legislation.⁵³² While the United Kingdom government asserted that persons with mental disabilities are prone to pursuing vexatious litigation, it did not have evidence to support its assumption.⁵³³ The European Court restricted its analysis to the United Kingdom law’s effect on the applicant and found that the law hindered his recourse to the national courts.⁵³⁴ Nevertheless, the Court was of the opinion that the applicant was unlikely to prevail on the merits.⁵³⁵ Therefore, based on the circumstances as a whole, the European Court found that the law did not violate Article 6 as it applied to *Ashingdane*.⁵³⁶ The European Court’s decision implies that a state can bar a person

525. *Osman v. United Kingdom*, 1998-VIII Eur. Ct. H.R. 3124, 3169.

526. *Winterwerp v. The Netherlands*, 33 Eur. Ct. H.R. (ser. A) at 29 (1979).

527. *Id.*

528. *Id.* at 15.

529. *Matter v. Slovakia*, App. No. 31534/96, at 3 (July 5, 1999) (Court report), at <http://hudoc.echr.coe.int>.

530. *Bock v. Germany*, 150 Eur. Ct. H.R. (ser. A) at 8 (1989).

531. *B v. United Kingdom*, App. No. 9840/82, 10 Eur. H.R. Rep. 87 (1987) (Court report); *H v. United Kingdom*, App. No. 9580/81, 10 Eur. H.R. Rep. 95 (1987) (Court report); *P., C. and S. v. United Kingdom*, App. No. 56547/00 (July 16, 2002) (Court report), at <http://hudoc.echr.coe.int>.

532. *Ashingdane v. United Kingdom*, 93 Eur. Ct. H.R. (ser. A) at 25-26 (1985).

533. *Id.* at 25.

534. *Id.*

535. *Id.* at 25-26.

536. *Id.*

from access to a court to determine the merits of her case merely because the claim may fail. The very essence of Article 6, however, is that citizens have rights of access to the judicial system to pursue their claims.⁵³⁷ If the claims are without merit, the domestic courts are free to dismiss them after hearing the evidence.

2. *The Right to a Private and Family Life and the Right to Marry and Found a Family.*—Article 8 of the ECHR prohibits public authorities from interfering with a person's right "to respect for his private and family life, his home and his correspondence."⁵³⁸ This right is broad enough to encompass an entitlement "to establish and to develop relationships with other human beings, especially in the emotional field for the development and fulfillment of one's own personality."⁵³⁹ The primary objective is to protect the individual against arbitrary interference by public authorities, but Article 8 also imposes a positive obligation on government to respect private and family life.⁵⁴⁰ The state, for example, may have to adopt policies affirmatively "designed to secure" a "private life even in the sphere of the relations" among private citizens.⁵⁴¹

Governments can place limitations on Article 8 rights only "in accordance with the law" and where "necessary in a democratic society in the interests," *inter alia*, of public safety or the protection of health, morals, or the rights and freedoms of others.⁵⁴² Government limitations, moreover, must be proportionate to one of these legitimate governmental interests.⁵⁴³

The European Court has found a violation of Article 8 in a case involving the freedom of correspondence of a detained patient.⁵⁴⁴ The hospital and the patient's guardian had screened all outgoing post and determined which pieces of mail it would forward to the addressees, including letters of complaint about his medical treat-

537. ECHR, *supra* note 35, art. 6.

538. *Id.* art. 8(1).

539. *X. v. Iceland*, App. No. 6825/74, 5 Eur. Comm'n H.R. Dec. & Rep. 86, 87 (1976).

540. Several of the major cases involving Article 8 concern the custody and care of minors. *See, e.g.*, *T.P. v. United Kingdom*, 2001-V Eur. Ct. H.R. 120, 142 (holding that the State had a responsibility to disclose information to the mother regarding the reasons why the State took her child into protective care); *K. v. Finland*, 2001-VII Eur. Ct. H.R. 192, 235 (finding that the government's reasons for taking a child away from his mother were sufficient under Article 8).

541. *X. v. The Netherlands*, App. No. 8978/80, 8 Eur. H.R. Rep. 235, 238-39 (1985).

542. ECHR, *supra* note 35, art. 8(2).

543. *Nasri v. France*, App. No. 19465/92, 21 Eur. H.R. Rep. 458, 477 (1995).

544. *Herczegfalvy v. Austria*, 244 Eur. Ct. H.R. (ser. A) at 50-51 (1992).

ment.⁵⁴⁵ Similarly, the European Court accepted a settlement of a case involving the possible violation of the right of a patient to informational privacy.⁵⁴⁶ In the latter case, the detained patient had a troubled relationship with her mother, and her adoptive father had sexually abused her.⁵⁴⁷ Given that the mother was the nearest relative under the Act, she and the stepfather had access to highly confidential information regarding the patient, and the Act did not afford the patient a procedure by which she could re-designate the identification of her nearest relative.⁵⁴⁸

The right to a private life under Article 8 applies to sexual life, suggesting that a court would proscribe unreasonable interference with sexual relationships of persons in institutions.⁵⁴⁹ Yet, it is likely that a court would uphold reasonable rules restricting sexual activities. For example, the European Commission found that a prison did not violate Article 8 when it denied a prisoner unsupervised visits with his spouse.⁵⁵⁰

The European Court has also interpreted Article 8 to protect the rights of parents to have a continuing relationship with their children, even if the parents have mental disabilities.⁵⁵¹ The court has demon-

545. *Id.* However, a court in the United Kingdom has upheld a special hospital policy of random recording and monitoring ten percent of patient phone calls. *R (on the application of N) v. Ashworth Special Hosp. Auth.*, CO/4416/2000, at para. 22 (Q.B. May 11, 2001) (upholding Safety and Security in Ashworth, Broadmoor, and Rampton Hospitals Directions 2000). The court regarded the policy as a justified infringement of Article 8 because it was a proportionate measure necessary to achieve the legitimate aim of maintaining high security for potentially dangerous persons. *Id.*

546. *J.T. v. United Kingdom*, [2000] 1 FLR 909 (Eur. Ct. H.R. Mar. 30, 2000). For more information about the admissibility decision of the European Commission of Human Rights see [1997] EHRLR 436.

547. *Id.* para. 7.

548. *Id.* paras. 8-10. The parties agreed to a settlement based on a proposed change in the Mental Health Act that would allow detained patients to apply to the court to replace the nearest relative when a patient reasonably objected to having that person named. *Id.* para. 12. The amendment would also allow patients to exclude particular people from acting as a "nearest relative." *Id.* The settlement also included a small amount of monetary compensation. *Id.*

549. *See Dudgeon v. United Kingdom*, 4 Eur. H.R. Rep. 149, 160, 168 (1981) (Court report) (finding a violation of Article 8 where laws making homosexual conduct criminal caused the applicant psychological stress and fear and interfered in his right to a private life).

550. *See Council of Europe, Human Rights Files No. 5, Conditions of Detention and the European Convention on Human Rights and Fundamental Freedoms* (1981). The European Commission declined an application by a Swiss married couple claiming a violation of Article 8 when they were detained in the same prison for two months without being able to see each other unsupervised. *Id.* at 18. The European Commission and the prison authority justified their actions on the grounds of prevention of disorder in the prison. *Id.* at 19.

551. *K. v. Finland*, 2001-VII Eur. Ct. H.R. 192, 228.

strated a clear aversion to complete separation between parents and their children.⁵⁵² While recognizing that state authorities “enjoy a wide margin of appreciation in assessing the necessity of taking a child into care[,]” the court has determined that restrictions on interaction between parents and their children deserve “stricter scrutiny.”⁵⁵³ A critical component of this analysis is whether the government’s actions are “necessary in a democratic society[,]” with a preference that the state take actions to allow as much interaction between parents and children as is possible under the circumstances, even if it places additional burdens on the state.⁵⁵⁴ Also, the Court found a violation of family life when local authorities did not allow the parents to have legal representation at their newborn child’s adoption hearing.⁵⁵⁵

Article 12 guarantees a particular aspect of the right to a private life—the entitlement of adults to marry and to found a family.⁵⁵⁶ Government may be considered to have violated the right to marry and found a family if it prohibits or unreasonably delays the marriage of a competent adult.⁵⁵⁷ The European Commission held that the right to marry was, in essence, a right to forge a legally binding association between a man and a woman.⁵⁵⁸ The government should not be able to deny this right solely because one of the partners is in prison and the couple will not be able to live together.⁵⁵⁹ This principle undoubtedly also applies to persons with mental disabilities detained for substantial periods of time.

Apart from these instances, surprisingly few mental health cases under Articles 8 and 12 have been litigated in the European system despite the relevance of private and family life to persons with mental disabilities. It is not difficult to think of other potential claims under Articles 8 and 12, e.g., the right to privacy and confidentiality, to soli-

552. *Id.*

553. *Id.*

554. *See Kutzner v. Germany*, App. No. 46544/99, at 11, 15 (2002) (Court report), at <http://hudoc.echr.coe.int> (rejecting government imposed restrictions on parents’ visiting rights with children because the government’s aims, while “relevant,” were “insufficient to justify such a serious interference in the applicant’s family life”) (internal quotation marks omitted).

555. *P. v. United Kingdom*, App. No. 56547/00, at 33-34 (July 16, 2002) (Court report), at <http://www.hudoc.echr.coe.int>.

556. ECHR, *supra* note 35, art. 12.

557. *See Hamer v. United Kingdom*, App. No. 7114/75, 24 Eur. Comm’n H.R. Dec. & Rep. 5, 14-15 (1979).

558. *Id.* at 13.

559. *Draper v. United Kingdom*, App. No. 8186/78, 24 Eur. Comm’n H.R. Dec. & Rep. 72, 81 (1980).

tude in one's home, and to relationships with children, parents, and other family members.⁵⁶⁰

Consider a person's claim that certain compulsory powers that restrict or force associations with family violates the right to family and private life. If mental health authorities forbid visits with family or deprive patients of their autonomy or liberty, in spite of family objections, genuine issues may arise under Article 8.

In summary, the ECHR has defended the civil rights of persons with mental disabilities in a variety of contexts. The European Court has afforded individuals the right of access to the national judicial system, the right to a private and family life, including the freedom to communicate, and the right to a sexual life and marriage.

3. *The Right to Life*.—The various human rights systems have construed the right to life both positively and negatively. Clearly in the civil and political sphere, the right to life, as conceived by the United Nations and regional systems, enjoins the government from taking away life without justification.⁵⁶¹ Moreover, a more limited affirmative interpretation has emerged from regional right to life jurisprudence, suggesting that in certain extreme circumstances the failure of the government to take steps to guard against foreseeable risk, or even to provide services needed to avert loss of life, violates this right. Both the European Court⁵⁶² and the Inter-American Commission⁵⁶³ have applied the right to life to situations affecting persons with mental disabilities, and all three regional courts have found right to life violations in other contexts.⁵⁶⁴

560. See, e.g., Eur. Comm'n H.R., *Stock-taking on the European Convention on Human Rights*, Supplement 1987, at 16 (1988) (noting that a parent's relationship with her child is a fundamental element of family life). But see *Re F* [2000] 2 FCR 481, in which the High Court found no violation of Article 8 in a case involving termination of parental rights.

561. *Edwards v. United Kingdom*, App. No. 46477/99, at 15 (Mar. 14, 2002) (Court report), at <http://www.echr.coe.int>.

562. See *id.* at 16, 18 (finding a right to life violation where a prisoner murdered his cell mate and the government was aware of the prisoner's "extreme dangerousness" before the murder but did not inform prison authorities).

563. See *Victor Rosario Congo v. Ecuador*, Case 11.427, Inter-Am. C.H.R. 63/99, para. 82 (1999), <http://www.cidh.oas.org/annualrep/98eng/Merits/Ecuador%2011427.htm> (holding that a State violated an inmate's right to life by failing to provide him with adequate nutrition and hydration, which caused the inmate's death).

564. *Hernández Lima v. Guatemala*, Case 11.297, Inter-Am. C.H.R. 28/96, paras. 58-61 (Oct. 16, 1996), <http://www.cidh.oas.org/annualrep/96eng/Guatemala11297.htm> (finding a violation of the right to life where the state did not take adequate steps to prevent a detained individual from getting cholera in prison); Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine des Droits de L'Homme, *Les Témoins de Jehovah v. Zaire*, African Comm'n Human & Peoples' Rights, Comm. No. 25/89, 47/90,

The European Court of Human Rights examined the right to life under Article 6 (the right to a fair trial) in the context of mental health. In *Edwards v. United Kingdom*, the court held that the British government breached its duty under Article 2 to protect the life of a prisoner named Christopher Edwards.⁵⁶⁵ Richard Linford, a cellmate who was known to be a dangerous person diagnosed with schizophrenia, murdered Mr. Edwards.⁵⁶⁶ The court declared:

[T]he failure of the agencies involved in this case (medical profession, police, prosecution and court) to pass on information about Richard Linford to the prison authorities and the inadequate nature of the screening process on Richard Linford's arrival in prison disclose a breach of the State's obligation to protect the life of Christopher Edwards.⁵⁶⁷

In the *Congo* case, the Inter-American Commission also found violations of the right to life under Article 4(1) of the American Convention.⁵⁶⁸ The Commission issued a strong indictment of the treatment of Mr. Congo by the government of Ecuador, finding that the government "failed to take the measures in its power to ensure the right to life of a person who, partly because of his state of health and in part owing to injuries inflicted on him by a State agent, was defenseless, isolated and under its control."⁵⁶⁹ According to the Inter-American Commission, this failure to act violated Mr. Congo's right to life.⁵⁷⁰

As these decisions demonstrate, the regional human rights systems have been willing to find violations of the right to life where governments have grossly neglected the treatment needs of persons with mental disabilities in the custody of the state, or have placed these persons in situations that expose them to a serious risk of harm or mental and physical deterioration.

V. THE RIGHT TO MENTAL HEALTH

The task of defining and enforcing civil and political rights required vast scholarship and litigation in international fora.⁵⁷¹ This Article has tracked the continuing evolution of civil and political rights

56/91, 100/93, para. 43 (finding that extrajudicial executions, arbitrary arrest, arbitrary detentions, and torture violated the right to life).

565. App. No. 46477/99, at 18.

566. *Id.* at 16.

567. *Id.* at 18.

568. Victor Rosario Congo v. Ecuador, Case 11.427, Inter-Am. C.H.R. 63/99, para. 84 (1999), <http://www.cidh.oas.org/annualrep/98eng/Merits/Ecuador%2011427.htm>.

569. *Id.*

570. *Id.*

571. GOSTIN & LAZZARINI, *supra* note 1, at 30.

in the United Nations human rights infrastructure. It has also demonstrated the systematic development of civil and political rights by the European Court of Human Rights and to a lesser extent by the other regional human rights systems. The international and regional human rights communities, on the other hand, have largely neglected economic, social, and cultural rights. However, governments should give economic, social, and cultural rights, notably the right to mental health, the same rigorous and sustained consideration that they have given to civil and political rights.⁵⁷²

The relative importance of civil and political rights versus economic, social, and cultural rights undergirds one of the most important and controversial disputes in the human rights community. Many countries, particularly democracies in the Northern and Western Hemispheres, feel that civil and political rights should take precedence.⁵⁷³ From this perspective, human rights law constrains the state from imposing on autonomy or liberty rights, but does not likewise give rise to affirmative obligations to provide services.

A persuasive argument may be made, however, that governments should consider economic, social, and cultural rights as being equally important as civil and political rights. The text of the major human rights instruments provides the principal support for this position. The United Nations Charter, in its preamble, articulates a determination to “promote social progress and better standards of life” and to “employ international machinery for the promotion of the economic and social advancement of all peoples.”⁵⁷⁴ Various other international instruments have built upon this idea in the decades since the Charter was established. Article 22 of the UDHR characterizes social and economic rights as “indispensable for [a person’s] dignity and the free development of his personality.”⁵⁷⁵ The ICESCR comprises the foundation for economic, social, and cultural rights under the United Nations treaty structure.⁵⁷⁶ The provisions of the ICESCR oblige governments to adhere to affirmative duties to promote social and economic development.⁵⁷⁷ The ICESCR recognizes in its Preamble that

572. *Id.*

573. Lawrence O. Gostin, *Beyond Moral Claims: A Human Rights Approach in Mental Health*, 10 CAMBRIDGE Q. HEALTHCARE ETHICS 264, 270 (2001).

574. U.N. Charter, *supra* note 69, pmbl.

575. UDHR, *supra* note 74, art. 22.

576. See ICESCR, *supra* note 87, art. 1, 993 U.N.T.S. at 5 (“All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.”).

577. See generally ICESCR, *supra* note 87, 993 U.N.T.S. at 3 (setting out the duties required by all states that are parties to the ICESCR).

both economic, social, and cultural rights and civil and political rights are necessary to achieve the goals and freedoms envisioned by human rights law.⁵⁷⁸ Governments can limit economic, social, and cultural rights under the ICESCR only as “compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.”⁵⁷⁹ The Vienna Declaration supports the view that “[a]ll human rights are universal, indivisible and interdependent and interrelated.”⁵⁸⁰

Economic, social, and cultural rights also warrant respect because they are in some ways more foundational than civil and political rights. Minimal levels of social and economic status, including sufficient conditions of health, are a prerequisite to the exercise of civil and political rights. Without a fundamental government obligation to satisfy basic health needs, including mental health, other rights would become less meaningful and unattainable for portions of the population. Indeed, the modern human rights community has increasingly recognized the importance of economic, social, and cultural rights.⁵⁸¹ Nevertheless, economic, social, and cultural rights often suffer in national public policy discourse because they can be costly to secure and may only address concerns salient to small—and politically powerless—groups within a society.⁵⁸²

A. Development of the Right to Mental Health Under International Human Rights Systems

The right to health, including mental health, is rooted in the economic, social, and cultural rights found in numerous international documents. The UDHR acknowledges the right to health as a component of “a standard of living adequate for the health and well-being of [a person and that person’s] family, including . . . medical care and

578. The Preamble of the ICESCR states that the “ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social, and cultural rights, as well as his civil and political rights.” *Id.* pmbl., 993 U.N.T.S. at 5.

579. *Id.* art. 4, 993 U.N.T.S. at 5.

580. Vienna Declaration, *supra* note 144, para. 5.

581. See Audrey R. Chapman, *Monitoring Women’s Right to Health Under the International Covenant on Economic, Social and Cultural Rights*, 44 AM. U. L. REV. 1157, 1159 (1995) (discussing the need for more monitoring of economic, social, and cultural rights); see also Goldberg, *supra* note 57, at 280-81 (describing health as an economic, social, and cultural right that receives inadequate recognition and protection).

582. See generally Philip Harvey, *Human Rights and Economic Policy Discourse: Taking Economic and Social Rights Seriously*, 33 COLUM. HUM. RTS. L. REV. 363 (2002) (describing the conflict between utility-maximization and human rights protection in the context of the “right to work”).

necessary social services, and the right to security in the event of . . . sickness.”⁵⁸³ The ICESCR adopts a broad concept of health as a human right, declaring “the right of everyone to the . . . highest attainable standard of physical and mental health.”⁵⁸⁴ States must make efforts to fully realize this right, including “the creation of conditions which . . . assure to all medical service and medical attention in the event of sickness.”⁵⁸⁵ The MI Principles also afford a right to the “best available mental health care.”⁵⁸⁶

Other international and regional instruments have incorporated variations of the right to health into their respective texts. The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) includes “[t]he right to public health, medical care, social security and social services.”⁵⁸⁷ The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) recognizes a “right to protection of health and to safety in working conditions” and calls for the elimination of “discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services.”⁵⁸⁸ The Convention on the Rights of the Child (CRC) asserts that “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.”⁵⁸⁹

Regional instruments provide more detailed right to health provisions that more specifically outline State obligations. The European Social Charter conceives of a right to health that encompasses public health and health care.⁵⁹⁰ The European Social Charter also provides for job training, rehabilitation, and social resettlement of people with mental or physical disabilities.⁵⁹¹ The descriptive and expansive conception of the right to health advanced by the European Social Charter is mirrored in the Inter-American System’s Protocol of San Salvador, which in addition to calling for “enjoyment of the highest

583. UDHR, *supra* note 74, art. 25.

584. ICESCR, *supra* note 87, art. 12(1), 993 U.N.T.S. at 8.

585. *Id.* art. 12(2)(d), 993 U.N.T.S. at 8.

586. *MI Principles*, G.A. Res. 119, *supra* note 28, Principle 1, [1991] 45 U.N.Y.B. at 621.

587. ICERD, *supra* note 100, art. 5(e)(iv), 660 U.N.T.S. at 222.

588. CEDAW, *supra* note 98, arts. 11(1)(f), 12(1), 1249 U.N.T.S. at 18-19.

589. CRC, *supra* note 99, art. 24(1), 1577 U.N.T.S. at 52.

590. European Social Charter, signed Oct. 18, 1961, Europ. T.S. No. 35, art. 11, available at <http://conventions.coe.int/Treaty/en/Treaties/Huml/035.htm> [hereinafter ESC] (describing the right to health as including an obligation by the contracting states to decrease the causes of illness and encourage through education and advice that every individual should take responsibility for her own health).

591. *Id.* art. 15.

level of physical, mental and social well-being" includes six specific areas within the right to health, including "[s]atisfaction of the health needs of the highest risk groups."⁵⁹² The African Charter on Human and Peoples' Rights contains "the right to enjoy the best attainable state of physical and mental health" requiring the State to "take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."⁵⁹³

Despite the widespread recognition of the right to health across these multiple sources, the scope and definition of the right to health has remained vague and variable until recently.⁵⁹⁴ The existence of a right to health is confirmed by numerous references in international human rights instruments, but the varying terminology and lack of specific elaboration have left the extent of the right unclear. Unlike many issues related to civil and political rights, the regional human rights systems did not provide significant jurisprudential development to illuminate the contours of the right to health.⁵⁹⁵ An ongoing debate persists in the human rights community over the meaning and content of the right to health.⁵⁹⁶

592. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), *adopted* Nov. 17, 1988, art. 10(2)(f), *available at* <http://www.cidh.oas.org/Basicos/basic5.htm> [hereinafter San Salvador Protocol]. There are five other areas within the right to health that states must make efforts to ensure:

a. Primary health care, that is, essential health care made available to all individuals and families in the community; b. Extension of the benefits of health services to all individuals subject to the State's jurisdiction; c. Universal immunization against the principal infectious diseases; d. prevention and treatment of endemic, occupational and other diseases; [and] e. education of the population on the prevention and treatment of health problems.

Id. art. 10(2)(a)-(e).

593. African Charter, *supra* note 68, art. 16, 21 I.L.M. at 61.

594. For an extensive account of the development of the right to health, see TOEBES, *supra* note 36, at 3-26.

595. Regional human rights litigation invoking the right to health has occurred infrequently and usually within a broader complaint asserting violations of multiple rights. The Inter-American Commission, in particular, has recognized at least one explicit violation of the right to health under Article XI of the American Declaration. *See* Annual Report of the Inter-American Commission on Human Rights, Resolution No. 12/85, Case No. 7615 (Brazil) (March 5, 1985), *at* <http://www.cidh.oas.org/annualrep/84.85eng/Brazil7615.htm> (finding that building projects undertaken by Brazil that forced the Yanomani Indian Tribe to abandon its homes violated the tribe members' right to health and well-being under Article XI of the American Declaration of Human Rights). The jurisdiction of the Inter-American Commission includes only violations of the right to education and rights of trade unions. TOEBES, *supra* note 36, at 186-87. Thus, the Protocol of San Salvador will not allow individuals to complain about a violation of their right to health. *Id.*

596. *See* GOSTIN & LAZZARINI, *supra* note 1, at 27-30 (examining the disagreement over the meaning of the right to health); Mann et al., *supra* note 41, at 11-18 (discussing three relationships between health and human rights); TOEBES, *supra* note 36, at 245-59 (explor-

Earlier scholarly analysis has explored an “ideology of entitlement”—the idea that international human rights law affords a right to mental health.⁵⁹⁷ The conceptualization of mental health as a human right, and not simply a moral claim, suggests that states possess binding obligations to respect, defend, and promote that entitlement. Considerable disagreement exists, however, as to whether “mental health” is a meaningful, identifiable, operational, and enforceable right, or whether it is merely aspirational or rhetorical.⁵⁹⁸ A right to mental health that is too broadly defined lacks clear content and is less likely to have a meaningful effect.⁵⁹⁹ For example, if health is, in the World Health Organization’s words, truly “a state of complete physical, mental and social well-being,” then no one can ever achieve it.⁶⁰⁰ Even if this definition were construed as a reasonable, as opposed to an absolute standard, it remains difficult to implement, and is unlikely to be justiciable.⁶⁰¹

Therefore, it is vital to delineate an unambiguous definition for the right to health that helps clarify state obligations, identify violations, and establish criteria and procedures for enforcement.⁶⁰² To clarify the issue, the United Nations Committee on Economic, Social

ing the scope of the right to health); Kinney, *supra* note 39, at 1474-75 (discussing the difference in the meaning of the right to health in the United States and the rest of the world); David P. Fidler, *International Law and Global Public Health*, 48 U. KAN. L. REV. 1, 40-48 (1999) (analyzing the right to health under various frameworks such as a government’s failure to give the public access to general health services); *see also* Jamar, *supra* note 39, at 8-17 (exploring broad and narrow definitions of the right to health); Rosalia Rodriguez-Garcia & Mohammad N. Akhter, *Human Rights: The Foundation of Public Health Practice*, 90 AM. J. PUB. HEALTH 693, 694 (2000) (describing how health professionals protect the human rights of HIV/AIDS patients by preserving their right to privacy, providing them with “equal access to medical care,” and helping them retain employment).

597. Larry O. Gostin, *The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry*, in MENTAL ILLNESS: CHANGES AND TRENDS 27, 27-54 (Philip Bean ed., 1983); *see* Larry Gostin, *The Mentally Ill and the Power of the State*, in LIBERTY AND LEGISLATION, *supra* note 47, at 76, 83-84 (proposing human rights principles that should guide a state’s relationship with the mentally ill); *see also* Larry Gostin, *Human Rights in Mental Health*, in PSYCHIATRY, HUMAN RIGHTS, AND THE LAW 148, 148-49 (Martin Roth & Robert Buglass eds., 1985) (discussing the definition of human rights in the context of mental health).

598. Lawrence O. Gostin, *The Human Right to Health: A Right to the “Highest Attainable Standard of Health,”* 31 HASTINGS CENTER REP., Mar.-Apr. 2001, at 29, 29.

599. *Id.*

600. *Id.* WHO’s Declaration of Alma Ata in 1978 reaffirms that: “[H]ealth, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.” WHO’s Declaration of Alma-Ata, decl. I, *adopted* September 6-12, 1978, available at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.

601. Gostin, *supra* note 598, at 29.

602. *Id.*

and Cultural Rights, which oversees the implementation and monitoring of the ICESCR, issued General Comment 14: The Right to the Highest Attainable Standard of Health.⁶⁰³ The General Comment explicates the right to health under the ICESCR, representing the most authoritative existing statement on the scope and meaning of the right to health.⁶⁰⁴

General Comment 14 conceives of a right to health that is extensive, fundamental, and “indispensable for the exercise of other human rights.”⁶⁰⁵ Thus, the right to health encompasses public health and health care, as well as other conditions that are necessary determinants for people to live healthy lives, including adequate nutrition, housing, uncontaminated drinking water, sanitation, safe workplaces, and a healthy environment.⁶⁰⁶ The right to health also contains both “freedoms and entitlements.”⁶⁰⁷ The freedoms are protections essentially drawn from the context of civil and political rights: the right to have control over one’s health and body, the right to sexual and reproductive freedom, and freedom from interference, which includes the right to be free from torture and medical treatment or experimentation without consent.⁶⁰⁸ The entitlements, by comparison, include an affirmative “right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”⁶⁰⁹ The General Comment considers the right to health in terms of broad norms, state obligations, violations, and implementation standards.

The General Comment explores the normative context of the right to health, citing the importance of availability, accessibility, acceptability, and quality within facilities, goods, and services.⁶¹⁰ The notion of “availability” requires the existence of the “underlying determinants of health, such as safe and potable drinking water” and sanitation, as well as functional health services, including trained health care professionals, adequate health treatment facilities, and access to essential medicines.⁶¹¹ The norm of “accessibility” ensures that health facilities, goods, and services are available to all, and prohibits discrimination and economic, geographic, physical, or informational barriers

603. *Id.*

604. *Id.*

605. General Comment 14, *supra* note 37, ¶ 1.

606. *Id.* ¶ 11.

607. *Id.* ¶ 8.

608. *Id.*

609. *Id.*

610. *Id.* ¶ 12.

611. *Id.* ¶ 12(a).

to access.⁶¹² Health services must be acceptable under medical ethics standards and from the perspective of cultural traditions.⁶¹³ Furthermore, health services must adhere to high quality standards that are scientifically and medically appropriate.⁶¹⁴

The state is faced with three obligations: to respect, protect, and fulfill the right to health.⁶¹⁵ Under the duty to respect, a state may not interfere “directly or indirectly with the enjoyment of the right to health.”⁶¹⁶ This duty mandates that a state refrain from limiting equal access to preventive, curative, and palliative health services, from impeding traditional preventive care and medical practices, and from engaging in deleterious environmental practices.⁶¹⁷ The state is further generally constrained from marketing unsafe drugs, with exceptions for treatment of mental illness and infectious diseases under certain conditions.⁶¹⁸ The obligation to protect requires the state to take affirmative measures to guarantee that traditional practices, private parties, and businesses do not interfere with the right to health.⁶¹⁹ The responsibility to fulfill obligates the state to facilitate and promote the right to health through positive measures that affirmatively enable and assist individuals and communities to fully enjoy the right to health.⁶²⁰ Appropriate measures to achieve this goal include legislative, budgetary, and promotional actions.⁶²¹ General Comment 14 cites a number of core obligations as vital to ensuring a minimal level of services: nondiscriminatory access to services, safe and adequate food, potable water, basic shelter and sanitation, essential drugs, reproductive and maternal services, immunization, infectious disease control, access to health information, and training of health personnel.⁶²²

Violations of the right to health may occur through either action or omission.⁶²³ For example, certain state policies actively deny access to health services, propagate policies that result in harm to the health

612. *Id.* ¶ 12(b).

613. *Id.* ¶ 12(c).

614. *Id.* ¶ 12(d).

615. *Id.* ¶ 33.

616. *Id.*

617. *Id.* ¶ 34.

618. *Id.* The Comment states that exceptions to marketing unproven drugs for mental illness should only be undertaken under limited conditions, in consultation with international standards such as the MI Principles. *Id.*

619. *Id.* ¶ 35.

620. *Id.* ¶ 36.

621. *Id.* ¶ 33.

622. *Id.* ¶¶ 43-44.

623. *Id.* ¶ 47.

of the public, or otherwise contravene the standards set in the General Comment; others, however, just fail to take sufficient steps toward the progressive realization of the right to health.⁶²⁴ A violation of the second type will not occur if the state merely has insufficient resources to comply but is willing to do so.

Finally, the General Comment outlines detailed implementation standards that require states to develop framework legislation that sets a national strategy, to devote resources to this strategy, to set goals and benchmarks to evaluate progress, and to establish appropriate procedures and remedies to hold violators accountable for their actions.⁶²⁵

The expansive and ambitious definition of the right to health developed by General Comment 14 could have a substantially beneficial impact on the lives of persons with mental disabilities.⁶²⁶ The establishment of a broad right to health increases the likelihood that national and local governments will augment the health services, including mental health services, available to the public. A broad right to health would likewise require governments to assure that mental health services and the determinants of good mental health were accessible, acceptable, and of appropriate quality, pursuant to the norms established in the General Comment.

Persons with mental disabilities and their advocates could utilize the General Comment 14 standards to insist that governments deliver on their obligations related to the right to health. As an illustration of how governments could use the right to health to achieve better conditions for persons with mental disabilities, consider the creation of community integration and treatment initiatives for persons with mental disabilities. The government's "duty to respect" the right to health mandates that it refrain from limiting equal access to mental health services, including treatment facilities and preventive mental health services.⁶²⁷ The "duty to protect" requires that the government take action to prevent private parties from interfering with the right to mental health.⁶²⁸ Thus, individuals could hold the government accountable pursuant to the right to health for failing to impose or enforce sufficient standards and regulations on community mental health care facilities or special residences for persons with mental dis-

624. *Id.* ¶¶ 48-52.

625. *Id.* ¶¶ 53-62.

626. Peter Mittler, *Meeting the Needs of People with an Intellectual Disability: International Perspectives*, in *DIFFERENT BUT EQUAL*, *supra* note 2, at 25, 26-31 (arguing that terminology and definitions, in order to be effective, must reflect human rights values).

627. *See* General Comment 14, *supra* note 37, ¶ 34.

628. *See id.* ¶ 35.

abilities.⁶²⁹ Finally, the “duty to fulfill” supports affirmative government efforts to ensure, for example, that they adequately provide mental health services in the community setting, make efforts to educate the public about mental disability, and undertake preventive and populational mental health initiatives.⁶³⁰

General Comment 14 highlights the linkages between the right to health and other human rights. From a normative perspective, this correlation of rights elevates the right to health so it has equal standing with other rights. From a practical perspective, it provides an additional tool to promote mental health through human rights. Many of the activities that violate the right to health may also transgress other human rights. An example of this can be seen in the interaction between the right to health and the right not to be subjected to inhuman and degrading treatment.⁶³¹ Regional courts in the Americas and Europe have found violations of the prohibition on inhuman and degrading treatment where a mentally ill person is detained in squalid, inhumane conditions and does not receive appropriate treatment.⁶³² However, the same actions that give rise to an inhuman and degrading treatment violation under these circumstances could also be seen as violating the right to health.⁶³³ Subjecting persons with mental disabilities to poor conditions while in confinement and failing to provide them with adequate medical and psychiatric treatment may result in significant physical and mental deterioration or even death; consequently, these conditions do not comport with the government’s obligations under the right to health. Thus, the incorporation of right to health claims along with other, more established, human rights claims in regional jurisprudence can help legitimize

629. *See id.*

630. *See id.* ¶ 36.

631. The Inter-American Convention actually combines its prohibition on inhuman and degrading treatment and its civil and political protection of health within Article 5 of the American Convention. American Convention, *supra* note 68, art. 5, 9 I.L.M. at 2-3. This provision establishes a right to “humane” treatment, a concept that encompasses protection against inhuman and degrading treatment and the right to physical and mental health. *Id.* However, the right to health found in this section has not been interpreted as broadly as in General Comment 14. General Comment 14, *supra* note 37, ¶ 4. The Protocol of San Salvador contains a much more detailed (and substantial) right to health that is more analogous to the scope of the right in General Comment 14. San Salvador Protocol, *supra* note 592, art. 10.

632. *See Keenan v. United Kingdom*, App. No. 27229/95, 33 Eur. H.R. Rep. 913, 964 (2001) (Court report) (finding inhuman and degrading treatment where a prisoner with known mental health problems was segregated for seven days without adequate medical care and subsequently committed suicide).

633. *See TOEBES*, *supra* note 36, at 264-66 (noting that the right to health covers inhuman and degrading treatment).

and solidify the right to health in these regional systems. More frequent utilization of the right to health will allow it to become part of a robust framework of rights protecting mental health, securing mental health services for those in need of them, and improving the related social determinants that affect mental health.

In 2002, the United Nations Commission on Human Rights appointed a Special Rapporteur with a mandate to focus on the right to the enjoyment of the highest attainable standard of physical and mental health.⁶³⁴ The Special Rapporteur, Paul Hunt, identified three primary objectives in his preliminary report in 2003: to promote, and encourage others to promote, “the right to health as a fundamental human right; to clarify the contours and content of the right to health; and to identify good practices for the operationalization of the right to health at the community, national, and international levels.”⁶³⁵ The Rapporteur will explore these objectives through two interrelated themes: the intersection of the right to health and poverty and of the right to health and prejudicial actions.⁶³⁶

Persons with mental disabilities stand to benefit greatly from the activities of the Special Rapporteur. Efforts to promote health as a fundamental human right, to the extent they are successful, will help establish an international baseline for acceptable compliance with the right to health. This will simultaneously create a floor of mental health services necessary to maintain a mentally healthy population. The identification of good practices for implementation of the right to health at all jurisdictional levels could have a far-reaching effect on the availability of health services for persons with mental disabilities. As the affirmative aspects of the right to health become more accepted internationally, national and local jurisdictions are more likely to provide and fund community mental health services. The Special Rapporteur’s designated focus areas will also necessarily address issues important to persons with mental disabilities.⁶³⁷

B. Problems with Definition, Standards, Implementation, and Enforcement

General Comment 14 is timely and relevant to persons with mental disabilities. The Comment addresses the right to health more

634. Hunt, *supra* note 38. The Commission on Human Rights appointed Paul Hunt, who is from New Zealand, in August 2002 for a three-year term. *Id.* at 2.

635. *Id.*

636. *Id.*

637. *See id.* at 22 (noting that persons with mental disabilities are especially susceptible to human rights violations).

systematically and extensively than any prior discussion of the right to health.⁶³⁸ Further, its provisions immediately apply to all states that have ratified the ICESCR.⁶³⁹ However, it is too soon to predict the practical effect the Comment will have on the recognition of the right to health worldwide.

If the right to health is to become tangible, rather than aspirational, international institutions and governments must not only heed the guidance of General Comment 14, but also must articulate achievable methods of implementing and enforcing its provisions.⁶⁴⁰ The failure to impose sufficient implementation and enforcement obligations—such as outcome measurement indices and international reporting systems—on national governments may eviscerate the practical importance of the right to health in international practice.⁶⁴¹ Two obvious obstacles may hinder widespread implementation. First, General Comment 14 directly applies only to countries that have ratified the ICESCR.⁶⁴² Therefore, countries not party to the ICESCR, such as the United States, are not legally bound to follow the right to health as outlined by the General Comment.⁶⁴³ While the standard advanced by General Comment 14 may eventually become customary international law, the universal acceptance of a broad right to health may nonetheless not occur for an extended period of time. Second, the level of implementation is partially contingent on the resources of the particular state.⁶⁴⁴ “The right to health” is not equivalent to the “right to be healthy[,]”⁶⁴⁵ since the attainment of good health depends on multiple determinants, including biological preconditions.⁶⁴⁶ Under the “progressive realization” standard of the ICESCR, governments with insufficient resources will not have to fulfill a robust right to health with any degree of immediacy or haste.⁶⁴⁷

Nevertheless, the drafting of General Comment 14 and the continuing mandate of the Special Rapporteur on Health hold promise

638. See General Comment 14, *supra* note 37, ¶ 4 (noting that the right to health incorporates a wide range of factors and determinants).

639. *Id.* ¶ 42.

640. See Kinney, *supra* note 39, at 1471 (describing the difficulties and importance of implementing General Comment 14’s guidance).

641. *Id.* at 1471-74.

642. General Comment 14, *supra* note 37, ¶ 42.

643. See Kinney, *supra* note 39, at 1471.

644. General Comment 14, *supra* note 37, ¶ 47.

645. *Id.* ¶ 8.

646. *Id.* ¶¶ 8-9.

647. *General Comment 3: Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights*, U.N. CESCR, 5th Sess., ¶ 9, U.N. Doc. E/1991/23 (1990), available at <http://www.cesr.org/ESCR/gencomment3.htm>.

for the future of the right to health and the application of this right to mental health. The aforementioned developments signal an increasing international interest in the right to health and have elucidated the clearest explanation yet of how human rights can affirmatively improve physical and mental health.

C. The Right to Health in a Mental Health Context

The right to health, to the extent that it exists in international instruments, necessarily and clearly includes both physical and mental health. Many of the international texts specifically mention “mental health” in their right to health guarantees. Those that do not explicitly mention mental health contemplate an ideal of health that encompasses mental as well as physical well-being.⁶⁴⁸ Just as it is difficult to address the right to health without contemplating other related human rights, it is difficult to consider mental and physical health separately in the context of human rights—a certain level of both mental and physical health are necessary to ensure the ability to enjoy and benefit from other human rights.

The right to health, together with other human rights, supports modern trends in mental health policy and practice, including community integration initiatives for persons with mental disabilities and the budding concept of public mental health.⁶⁴⁹ Community integration is based on the theory that persons with mental disabilities can receive effective treatment in a community setting.⁶⁵⁰ Community care does not involve as drastic a curtailment of civil and political rights as does institutionalization. Consequently, detention in a psychiatric facility should only occur under exceptional circumstances where the person requires continual psychiatric and medical care and poses a risk to himself or others.⁶⁵¹

648. See Gostin, *supra* note 573, at 271 (explaining that the right to mental health is noted both explicitly in international texts such as ICESCR and the African Charter on Human and Peoples’ Rights and implicitly in texts such as the Universal Declaration on Human Rights).

649. See INST. OF MEDICINE, THE FUTURE OF PUBLIC HEALTH 111-12 (1988) (discussing the need to continue developing the relationship between public health and mental health).

650. *Id.*

651. See *Winterwerp v. The Netherlands*, 33 Eur. Ct. H.R. (ser. A) at 18 (1979) (delineating the elements necessary to detain a person of unsound mind).

D. Two Fundamental Aspects of the Right to Mental Health: Individual Mental Health and Public Mental Health

The right to mental health contains two equally important components—the right to individual mental health and the right to public mental health. An individualized concept of mental health emphasizes the conditions most relevant to the mental health status of a particular individual.⁶⁵² This individual concept predominates most of the discourse related to human rights. Protecting the individual's interest in autonomy or liberty is the basis for most civil and political rights. Certain components of social and economic rights focus on the individual as well; an affirmative right to health can be construed to apply directly to the mental health care needs of a specific individual.⁶⁵³ If the government knowingly implements policies and practices that are harmful to the mental health of individuals, there may be a violation of the right to individual mental health. Similarly, if the state withholds services necessary to maintain the mental health of individuals, it may violate that same right.

By contrast, public mental health approaches issues of mental health from a population-based perspective.⁶⁵⁴ The human rights community has increasingly come to recognize the synergies between human rights and populational health.⁶⁵⁵ Thus, it is interesting and timely to conceive of human rights from the perspective of the needs of populations as opposed to individuals.

It is helpful to view public mental health through the prism of public health.⁶⁵⁶ The Institute of Medicine, in its seminal report *The Future of Public Health*, proposed one of the most influential contemporary definitions: "Public health is what we, as a society, do collectively to assure the conditions for people to be healthy."⁶⁵⁷ The emphasis on cooperative and mutually shared obligation ("we, as a society") re-

652. See, e.g., *MI Principles*, G.A. Res. 119, *supra* note 28, principle 9(2), [1991] 45 U.N.Y.B. at 622 (explaining that mental health practitioners should consult with the patient in formulating their course of treatment).

653. See HEALTH AND HUMAN RIGHTS, *supra* note 41, at 16 (commenting that identification of health impacts and violations of rights will help uncover burdens on mental well-being).

654. See LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 11-14 (2000) (explaining that public health research and actions benefit the "collective population").

655. See HEALTH AND HUMAN RIGHTS, *supra* note 41, at 16 (noting the needs for increased capacity to utilize public health methods to study and identify human rights violations).

656. See generally GOSTIN, *supra* note 654, at 3-22 (explaining the public health system); PUBLIC HEALTH LAW & ETHICS: A READER (Lawrence O. Gostin ed., 2002).

657. INST. OF MEDICINE, *supra* note 649, at 19.

inforces that collective entities (i.e., governments) should take responsibility for mentally healthy populations.⁶⁵⁸

Public mental health goes beyond merely providing care and rehabilitation services. Rather, the state must assure the existence of multiple conditions in which people can be mentally healthy.⁶⁵⁹ Many policies and practices affect mental health—including those that give people a sense of belonging and purpose, and those that reduce highly stressful conditions.

The more extensive descriptions of the right to health, such as those found in General Comment 14 and in some of the regional human rights instruments, directly mention population-based health obligations that fit well within the traditional public health paradigm. For example, General Comment 14 requires states to facilitate efforts to improve health for both individuals and communities.⁶⁶⁰ These efforts include public health functions such as immunization, infectious disease control, and access to health information in its list of core obligations.⁶⁶¹

At the regional level, the Protocol of San Salvador in the Inter-American System specifically includes public health requirements in its right to health provision.⁶⁶² The Protocol requires states to make efforts to ensure “[u]niversal immunization against the principal infectious diseases; [p]revention and treatment of endemic, occupational and other diseases; [e]ducation of the population on the prevention and treatment of health problems, and [s]atisfaction of the health needs of the highest risk groups.”⁶⁶³ The European Social Charter’s right to health similarly embraces components of public health practice, charging states “to remove as far as possible the causes of ill-health; to provide advisory and educational facilities for the promotion of health . . . ; to prevent as far as possible epidemic, endemic and other diseases.”⁶⁶⁴ The rights and duties created by these instruments compel states to take affirmative measures to buttress the foundations of public health within society.

We offer the following concise definition of public mental health:

658. *See id.* at 32, 112 (discussing the need for governmental health obligations, support of public health efforts, and the application of fundamental public health concepts to mental health).

659. *See id.* at 112 (suggesting there is a public health need to develop effective means to reduce the risks of mental illness).

660. General Comment 14, *supra* note 37, ¶¶ 36-37.

661. *Id.*

662. San Salvador Protocol, *supra* note 592, art. 10.

663. *Id.* (enumeration omitted).

664. ESC, *supra* note 590, art. 11 (enumeration omitted).

The duty of the state, within the limits of its available resources, to assure the conditions necessary for people to attain and maintain mental health.⁶⁶⁵

This definition places explicit obligations on the state, and recognizes that a claim to a right to mental health imposes a correlating duty.⁶⁶⁶ By acknowledging that states possess varying capabilities, this definition also requires a state to act only within the limits of its resources to secure the right to mental health.⁶⁶⁷ The definition does not impose an absolute standard because mental health is affected by many factors outside of government's control (e.g., genetics, behavior, and stressful conditions).⁶⁶⁸ However, it requires the state to ensure the conditions under which the public can be mentally healthy.⁶⁶⁹ Governments can do a great deal to improve the mental health of populations, including providing decent economic conditions, education and health information, opportunities for meaningful employment, social and welfare services, primary and secondary mental health care, community mental health services, and hospital-based treatment and services.⁶⁷⁰

Governments can also positively affect mental health by improving the underlying societal conditions that would otherwise negatively impact the mental health of populations. Governments can help organize social life to avoid stressful conditions and promote positive mental health—for example by implementing policies that favor humane work conditions, time and space for recreation and relaxation, and assistance with stress-causing circumstances such as child rearing and debt. Government obligations, then, go beyond the provision of individual psychiatric services. Governments should also assure a broad array of services that are necessary for populations to maintain mental health.⁶⁷¹ The definition does not, however, guarantee a minimal standard of mental health because, given widely disparate resource levels, a single international standard would be unworkable.⁶⁷²

The application of public health methods to mental health practice, within the boundaries and context of human rights, could yield positive results for persons with mental disabilities and for the public's mental health generally. For instance, government could attempt to

665. Gostin, *supra* note 573, at 271.

666. *Id.*

667. *Id.*

668. *Id.*

669. *Id.*

670. *Id.* at 271-72.

671. *Id.* at 272.

672. *Id.*

raise public awareness about mental disability issues. The use of public education campaigns—a staple of regular public health practice—to reduce the stigma and fear surrounding mental disability, can reduce the estrangement of mentally disabled individuals from the community.⁶⁷³ Efforts to promote greater understanding and acceptance of persons with mental disability by others in the community will bolster community integration initiatives and provide persons with mental disability with an opportunity to live richer, fuller, and more interactive lives in the community. Education campaigns can also serve preventive goals, informing the public about the availability of mental health care services for themselves and others about whom they care.⁶⁷⁴ Finally, public mental health education campaigns can advance the public policy debate over the rights of persons with mental disabilities, from both an individual and community perspective.

The application of other disciplines, such as screening and epidemiology, can also benefit mental health. Epidemiological investigations into the incidence and prevalence of mental health conditions can help identify trends and concentrations of mental disability in the community.⁶⁷⁵ Governments can then use this information to target scarce resources to assist those in need of mental health care or related interventions.⁶⁷⁶ Initiatives to detect and rapidly identify persons with mental disabilities will allow for the detection of mental disabilities before they worsen, and permit timely intervention. This will, in turn, improve the mental health of those at risk of developing a mental disability and enhance the aggregate mental health of the entire community.

Lastly, public mental health can improve mental health in the population through its efforts related to other areas of health. Public health practice excels at reducing the underlying determinants of disease and injury.⁶⁷⁷ General Comment 14 recognizes the underlying determinants of health as central to the state's duty under the right to health.⁶⁷⁸ This relationship applies equally well to mental health conditions—maintaining good conditions in the environment, safe food and water, and adequate shelter and sanitation will help preserve a

673. See GOSTIN, *supra* note 654, at 150-51 (discussing governments' use of public education campaigns to raise awareness about public health concerns).

674. See *id.*

675. INST. OF MEDICINE, *supra* note 649, at 111-12.

676. *Id.* at 111.

677. *Id.* at 40-41.

678. General Comment 14, *supra* note 37, ¶ 4.

higher level of mental health than would occur in the absence of these conditions.⁶⁷⁹ Thus, efforts by public health agencies to improve these conditions comprise an additional component of public mental health practice.⁶⁸⁰ The recognition of the importance of these underlying determinants in human rights norms gives them extra credence in public mental health practice.

Attention to mental health issues by public health agencies is integral to the realization of the right to mental health. Since most public health activity takes place at the local level, the incorporation of human rights norms into local policies and procedures may present a promising approach to using human rights standards to support the goals of public mental health. Law and policy instruction from national and international sources are necessary components of this endeavor, but concerted efforts at the local level to highlight the importance of human rights norms to public mental health will help to improve mental health conditions.

VI. THE FUTURE OF HUMAN RIGHTS FOR PERSONS WITH MENTAL DISABILITIES

International human rights law can do much to promote good mental health in the population generally and improve the lives of persons with mental disabilities. This Article provides some insight into the development of a remarkable, but still incomplete, human rights structure that acts as a potent means to achieve these goals. An intricate and dynamic human rights framework has been developed at the international and regional levels. The components of this framework—documents defining human rights, and institutions enforcing and interpreting them—have created evolving human rights systems that protect and guarantee fundamental rights to all, regardless of location or situation.⁶⁸¹ These international and regional mechanisms have increasingly demonstrated concern over abuses of human rights that affect persons with mental disabilities and awareness of the role that human rights can serve in preventing these abuses and fostering good mental health throughout the population.⁶⁸²

679. *See id.*

680. *See* INST. OF MEDICINE, *supra* note 649, at 112 (concluding that public health efforts in the mental health area should be consistent with overall public health goals).

681. *See* HEALTH AND HUMAN RIGHTS, *supra* note 41, at 9-11 (stating that various documents, such as the Universal Declaration of Human Rights, have set forth human rights standards that are becoming a part of global life).

682. *See generally* Herr, *supra* note 22, at 115 (outlining the history of human rights agreements and discussing how governments can use them to improve mental health).

The various systems for the protection of human rights present the opportunity to provide tangible human rights protection for persons with mental disabilities at both the individual and populational level. Reporting, investigatory, and adjudicatory mechanisms allow for the detection and prevention of human rights violations in the context of mental health.⁶⁸³ In some circumstances, particularly under the regional institutions, individuals may bring their grievances directly to human rights institutions to obtain specific relief from violations.⁶⁸⁴ Reports or decisions by human rights bodies, therefore, have a potentially powerful effect on the lives of persons with mental disabilities. Moreover, to the extent that these decisions interpret and clarify the scope and application of human rights to persons with mental disabilities, they provide generalizable principles applicable to subsequent government activities and enforcement.⁶⁸⁵ These generalizable principles can promote mental health for individuals and populations. In the individual context, persons with mental disabilities facing similar conditions will receive the protection of established human rights norms.⁶⁸⁶ In the public mental health context, governments will have an obligation to create conditions to protect and promote the mental health of the populace.

Persons with mental disabilities will benefit from the continual development of human rights systems at the international and regional levels. The respective systems play different but complementary roles in building and reinforcing a vibrant and enforceable human rights structure for the protection and promotion of the rights of persons with mental disabilities. The United Nations System continues to progressively enhance its human rights framework through efforts to enact new instruments, both binding and nonbinding, to protect mental health within the rubric of human rights.⁶⁸⁷ Initiatives such as the proposed international convention on disability and the ongoing mandate of the Special Rapporteurs on Health and Disability

683. See *id.* at 128-35 (discussing the implementation of human rights standards related to intellectual disabilities through reports, resolutions, nongovernmental organizations, and case law).

684. *Id.* at 126.

685. See *id.* at 132-33 (noting that *Wyatt*, a mental disability rights case, led to refinement of standards in many subsequent disability rights cases).

686. See HEALTH AND HUMAN RIGHTS, *supra* note 41, at 10-11 (suggesting that increased focus and implementation of human rights standards could lead to human rights norms becoming global standards).

687. See Hunt, *supra* note 38, ¶¶ 90-94 (specifically recognizing the right to mental health and the need for improved access to this right).

Rights advance the development of stronger, more enforceable rights for persons with mental disabilities.⁶⁸⁸

Regional human rights systems offer a substantial opportunity to provide additional human rights protection for persons with mental disabilities. The development of human rights jurisprudence at the regional level, particularly in the European system, has refined international understanding of the applicability of human rights to mental health and has extended the scope of this understanding.⁶⁸⁹ The unique jurisdiction and mandate of the regional institutions has facilitated these efforts. The ability of individuals, and in some cases NGOs, to directly access regional institutions has allowed the victims of human rights abuses to take more proactive steps to shed light on these abuses and prevent them from recurring.⁶⁹⁰ Individual access to regional courts has provided an opportunity for victims of human rights abuses to receive direct redress for the abuses, through compensation or otherwise.⁶⁹¹ The collective jurisprudence of the regional systems has established significant protections for persons with mental disabilities.⁶⁹² Regional institutions have frequently forwarded novel and innovative interpretations of how governments should apply human rights to mental health.⁶⁹³ Moreover, regional institutions have shown a demonstrable and laudable tendency to adopt precedents from international instruments, such as the MI Principles, and from the jurisprudence of other regional systems.⁶⁹⁴ Pursuant to this tradition, the regional systems may be the first venues to decipher, interpret, and apply the right to health outlined in General Comment 14. The structure of the regional systems has yielded a focus and flexibility not found in the United Nations System—therein lies their

688. *See id.*

689. *See* GOSTIN & LAZZARINI, *supra* note 1, at 11 (stating that the European system has produced the most extensive regional human rights jurisprudence).

690. *Id.* at 10-11.

691. *See, e.g.,* ECHR, *supra* note 35, art. 5(5) (providing victims of unlawful arrest or detention a right to compensation).

692. *See* Fennell, *supra* note 247, at 110-15 (examining developments of the European Court of Human Rights in mental health policy and rights); *see also* Harding, *supra* note 247, at 258-68 (discussing benefits and drawbacks of the ECHR's influence on mental health policies).

693. Harding, *supra* note 247, at 260-62.

694. *See, e.g.,* Victor Rosario Congo v. Ecuador, Case 11.427, Inter-Am. C.H.R. 63/99, para. 54 (1999), <http://www.cidh.oas.org/annualrep/98eng/Merits/Ecuador%2011427.htm> (utilizing the MI principles as guidance).

promise in playing a continuing prominent role in the area of mental health and human rights.⁶⁹⁵

The enforcement of existing human rights instruments in the United Nations System has not measured up well to its regional counterparts. United Nations institutions have the authority under existing international law to engage more proactively in the protection and promotion of the human rights of persons with mental disabilities, regardless of the status of new conventions or other initiatives.⁶⁹⁶ When the U.N. Commission on Human Rights has strongly pursued fact-finding investigations in the past, it has successfully pressured national governments to revise mental health laws that violate human rights. For instance, in 1985, criticism of Japan's mental hygiene law based upon the conclusions of a fact-finding mission spurred the Japanese government to institute serious reforms to their mental health system.⁶⁹⁷ The use of fact-finding expeditions and critical reports from United Nations monitoring committees, special rapporteurs, and human rights NGOs can exert pressure on governments which fail to respect human rights. These efforts are vital to the continued evolution of human rights protections for persons with mental disabilities.

The rise of the right to health as an important concept in international human rights law is also crucial to the interests of persons with mental disabilities. Development of an international consensus on the right to health is ongoing and may prove difficult across the complicated landscape of international human rights systems.⁶⁹⁸ Indeed, it may take many years for the broad conception of the right to health envisioned by the authors of General Comment 14 to become a practi-

695. Dinah Shelton, *The Promise of Regional Human Rights Systems*, in *THE FUTURE OF INTERNATIONAL HUMAN RIGHTS* 351, 352-53 (Burns H. Weston & Stephen P. Marks eds., 1999).

696. See generally Richard B. Bilder, *An Overview of International Human Rights Law*, in *GUIDE TO INTERNATIONAL HUMAN RIGHTS PRACTICE*, *supra* note 63, at 3, 7-15 (providing an overview of international human rights law and its enforcement).

697. See Gostin, *supra* note 46, at 362. At the time, Japan had over 30,000 persons in civil confinement on consent given by third parties. The accompanying report accused Japan of violating section 9(4) of the ICCPR. *Id.* Japan agreed in the wake of the report to revise its law. See LAWRENCE O. GOSTIN, *HUMAN RIGHTS IN MENTAL HEALTH IN JAPAN* (1987); Gostin, *supra* note 46, at 353, 361-62. NGOs have had success using similar tactics. Mental Disability Rights International's report on Mexican mental asylums prompted a negative report from the Inter-American Commission and the subsequent revision of national mental health policies. Mental Disability Rights International, *Human Rights & Mental Health: Mexico*, at 58 (September 2000), available at <http://www.mdri.org/publications/index.htm>.

698. Cf. TOEBES, *supra* note 36, at 16-17 (describing controversy over use of the term "right to health").

cal reality. Nevertheless, substantial efforts to establish a strong right to health continue at the international and regional levels.⁶⁹⁹ International institutions and NGOs have already begun to forge a strong international precedent for a more dynamic right to health.⁷⁰⁰ The activities of the Special Rapporteur on Health have also bolstered efforts in this direction.⁷⁰¹ Regional systems, which have already recognized a right to health in their foundational instruments and case law,⁷⁰² are poised to incorporate a broader interpretation of the right to health into their jurisprudence. Additionally, the promulgation of new human rights instruments and institutions related to disability rights could provide yet another venue for the expansion of an affirmative right to mental health.⁷⁰³ These collective efforts represent a burgeoning and multifaceted movement around the right to health that could have enormous positive consequences for persons with mental disabilities. It will be essential, however, to devote more focused attention to public mental health.

Finally, human rights norms that will protect and promote the interests of persons with mental disabilities do not have to exist solely at the international level. National governments may incorporate these norms into their domestic legislative structure. Many countries have undertaken serious efforts at mental health law reform, but many

699. See generally *id.* at 27-84 (describing international and regional actions to implement a right to health).

700. The World Health Organization (WHO) has been extremely active in the continuing development and understanding of the right to health. WHO has undertaken several initiatives to promote the right to health, including staff training in the right to health, publication of explanatory materials for the public, and consultation with the Special Rapporteur on Health. See *Written Submission by the World Health Organization*, U.N. ESCOR, Comm'n on Human Rights, 59th Sess., U.N. Doc. E/CN.4/2003/122 (2003), at 7, available at http://www.who.int/hhr/en/WHO_written_submission_59th_session.pdf. WHO is also in the process of developing a global health and human rights resource database and an annotated bibliography of health and human rights materials. *Id.* Moreover, the WHO has implemented a mental health Global Action Programme (mhGAP), which includes initiatives such as the WHO Mental Health Legislation Manual and an international forum on mental health and human rights that occurred in November 2003. *WHO Project*, *supra* note 31. For additional resources related to these WHO initiatives, see World Health Organization, *Health and Human Rights*, <http://www.who.int/hhr/en/> (last visited Nov. 11, 2003).

701. See Hunt, *supra* note 38, ¶¶ 90-94 (outlining the Special Rapporteur's approach to promoting the right to mental health).

702. See GOSTIN & LAZZARINI, *supra* note 1, at 11.

703. In addition to the proposed U.N. convention, the Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities created a new committee to monitor and report on the progress of disability rights by states in the Inter-American System. Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities, adopted June 7, 1999, art. VI, at <http://www.cidh.oas.org/basicos/disability.htm>.

others continue to have antiquated and obsolete laws that do not conform to human rights standards or provide adequate authority to implement these standards within a national system.⁷⁰⁴ Countries that wish to proceed may either modify their national legal systems to conform to human rights obligations, or incorporate international human rights jurisprudence as precedent in their national mental health schemes. Some countries, particularly those in the Council of Europe, have adopted both approaches.⁷⁰⁵ The existence of human rights standards at the national level ensures that individuals have the right to redress their grievances in a national forum and reduces the urgency of international oversight, assuming that the government is complying with the standards set out in the legislation.⁷⁰⁶ The WHO Mental Health Legislation Manual will provide a useful guide for national governments attempting to accomplish law reform.⁷⁰⁷

The human rights of persons with mental disabilities can be effectively protected and promoted through international human rights law. Regional systems have extensively developed civil and political rights that protect mentally disabled individuals.⁷⁰⁸ By contrast, economic and social rights, including the right to mental health, remain underutilized in all of the international systems, despite an emerging consensus on the existence and viability of these rights.⁷⁰⁹ New initiatives within the United Nations and regional systems hold significant promise for advancing the right to mental health under international law.⁷¹⁰ Similarly, the continued development of jurisprudence at the regional level will complement other efforts to improve the human rights protections and the lives of persons with mental disabilities.

Human rights are not a panacea for persons with mental disabilities. Nevertheless, focused attention on the civil and political, as well

704. See Rosenthal & Rubenstein, *supra* note 29, at 269-82 (discussing international efforts to implement the MI Principles).

705. The United Kingdom, for instance, has passed mental health legislation that incorporates many of the human rights norms addressed in this Article and has additionally passed legislation incorporating the case law of the European Court into its domestic law. Mental Health Act, 1983, c. 20 (Eng.); Human Rights Act, 1998, c. 42 (Eng.).

706. See Rosenthal & Rubenstein, *supra* note 29, at 287-88 (discussing the importance of domestic enforcement of international standards).

707. World Health Organization, *Mental Health and Human Rights Project*, available at http://www.who.int/mental_health/polity/legislation/humanrights/en (last visited Sept. 24, 2003).

708. See, e.g., ECHR, *supra* note 35 (delineating civil and political rights that European member states should respect).

709. See Gostin, *supra* note 573, at 270 (describing the view of most countries that civil and political rights are more important than economic and social rights).

710. See Hunt, *supra* note 38, ¶¶ 90-94 (setting forth the goals and methods for advancing the right to mental health).

as social and economic rights of this group is vitally important. Countries have treated persons with mental disabilities horribly throughout history and into the present.⁷¹¹ Governments have failed to serve their needs for treatment, care, and support, and have failed to protect their rights and dignity.⁷¹² This historical neglect and animus may end if the movement for human rights succeeds in lifting persons with mental disabilities from their historically inferior status.

711. *See id.* ¶ 93 (noting reports of human rights violations, such as torture and sexual exploitation, at institutions designated for treatment).

712. *See id.* ¶ 91 (asserting that mental health is a low priority for many governments).